THE ISSUES THAT LED TO DEVELOPMENT OF MEDICARE IN MANITOBA

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PREFACE

This study examines the background, the issues and the participation of different groups in the policy process surrounding the introduction of medical care in Manitoba. The question for many years was not whether Manitobans needed medicare, but by what means they should proceed toward that ultimate goal. The universal medicare programme of 1969 was the end product of a long series of developments which took place in Manitoba over the last twenty-five years. The thesis traces such developments, beginning with the growth of the physician-sponsored voluntary prepayment plans up to the eventual entry of Manitoba into the national plan in 1969.

To afford some appreciation of the factors that make health insurance very controversial, an attempt has been made in Chapter I to provide a background portrayal of federal involvement in health issues. Chapter II deals with the pre-medicare period in Manitoba.

The move from voluntary to government medical insurance is dealt with in Chapter III. The factors behind such change, provide an interesting insight into the changing pattern of Manitoba's social structure during that period.

Chapter IV provides an investigation of the role of the various participants in the policy process, namely, the role of the Manitoba Medical Association (MMA); the role of the insurance companies in Manitoba, especially the Manitoba Medical Service (MMS); the role of the various groups in the medicare conflict; the influence of the political parties; the impact of the province's relation with the federal government and the influence of the Department of Health.

The establishment of a universal medicare programme is but one facet of the still long road ahead. Chapter V indicates the consequences of Manitoba's decision to implement the federal medicare programme.

Much of the factual material used in this study was obtained from federal and provincial government documents, relevant books, reports, journals, newspapers, interviews, etc.

While there are studies of the Saskatchewan medicare struggle and issues surrounding the development of medicare in Ontario, and also Quebec's entry into the national plan, there is no such study of Manitoba's decision to enter the plan.

ACKNOWLEDGEMENT

Because health service problems grow in complexity, their solution will always be difficult. The task is beyond the capacity of any one profession, or any single organization, or any government. All must help. They will be assisted by knowledge which in itself is a strong force for bringing about reform.

I am especially obliged to Doctor Paul G. Thomas, whose patience, direction and encouragement, made this thesis a coherent document. My special thanks to my many friends, especially Ms. Daphne Tkachuk and Ms. B. Johnson, both of the Department of Health and Social Development; S. L. Armstrong, Librarian in Brandon; Mr. D. Doug Deegan, Communications Officer with the Manitoba Medical Association; the staff of the Government Documents, Dafoe Library, University of Manitoba, all of whom provided most of the material and information. Many will recognize their own ideas in these pages - whether specially acknowledged or not. How can one thank them all?

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The author takes responsibility for any inconsistencies found therein.

A.A.E.

CHAPTER I

GENERAL BACKGROUND TO FEDERAL INVOLVEMENT IN THE HEALTH FIELD

This chapter examines the general background of federal involvement in health care provided to Canadians. Saskatchewan has operated a universal medicare plan since 1962 and gradually, since 1967 medicare programmes have been added in all ten provinces and the two sparsely settled territories of the north. While the full study concentrates on the Province of Manitoba, federal involvement with the provinces as a group will be analyzed in this chapter. There is an overall similarity in the pattern of health services across the country, but there is also variety in emphasis, approach, and detail.

Any comprehensive review of health policies must consider the division of powers within the Canadian federal system between the Federal and Provincial Governments based upon the BNA Act of 1867. Section 91(11) of the Act assigns jurisdiction over quarantine and the establishment and maintenance of marine hospitals to the federal government. Section 92(7) provides provincial jurisdiction over the establishment, maintenance and management of hospitals, asylums, charities and charitable institutions in and for the provinces, other

than marine hospitals.[1] In the context of the circumstances existing in 1867, the latter reference probably was meant to cover most health care services. Furthermore, the provinces were assigned jurisdiction over matters of a local or private nature in Section 92 (13). This power was deemed to cover health care, while the provincial power over municipal institutions provided a convenient means for dealing with such matters. The provision of health care services has, therefore, traditionally been acknowledged as primarily a provincial responsibility.

Governmental involvement in health care services in 1867 was minimal. For the most part, the individual was compelled to rely on his own resources and those of his family group. Hospitals were administered and financed by private charities and religious organizations. Since the role of the state was modest, the subject of health could not be expected to claim an important place in the discussions leading up to Confederation, nor in the BNA Act. The Fathers of Confederation could not have foreseen the pervasive growth and range of health care needs of a large industrialized urban society, the advances of medical science, nor the public expenditures required to maintain high quality health care.

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[1] Canada, Laws, Statutes, etc., A Consolidation of the BNA Act 1867-1975, (Department of Supply and Services, 1976). See also, W. Houston, Documents Illustrative of the Canadian Constitution, (N.Y.: Libraries Press, 1970), p.205.

Changing concepts in the fields of health and welfare during the past century have led to involvement by all three levels of government and made the jurisdiction picture less precise. By 1967, the federal parliament was allocating roughly ten per cent of its funds for the provision of health care to the provinces.[2] The largest of these outlays was paid to the provincial governments in order that they might finance health care schemes in their provinces, but as most provincial governments have claimed, the federal parliament in doing so, exercised considerable leverage in determining the purposes for which these allocated monies could be spent. The federal government has used its constitutional authority to provide care for those within its jurisdiction, including Indians, federal government employees, Armed Forces Veterans, and peoples of the federal territories.

The entry of the federal government into the field of health policy is not difficult to explain. Social Services, particularly in the area of health, education and social security became, in the immediate post-World War II period, one of the major concerns of almost all governments in the Western World. Canada, especially with a tradition of a strong role for the state in the affairs of the community, was no exception. In a nation of considerable affluence,

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[2]Canada, Royal Commission on Health Services (Ottawa: Queen's Printer, 1964), Vol. I, p. 84. Henceforth cited as the Hall Commission. See also, Health Services in Canada: Report of working conference on the implication of a Health Charter for Canadians (Ottawa: Mutual Press, 1965), p. 8.

with a significant percentage of its population sharing in this affluence, and with a North American concern for equal opportunities for all, demands were articulated in the political arena for government programmes to provide these social services. In the field of health care, Manitoba, like the governments of the other provinces, was urged and challenged to accept responsibility for improved and extended care programmes. The financial resources required for a significant government role in this field were more readily found at the national level. Yet, provincial legislatures were still mainly responsible for the provision of health care and, in most cases, were not willing to see their jurisdiction relinquished to the federal parliament.[3]

The outcome of this dilemma was the offer by the federal government to underwrite 60 per cent of the estimated cost of provincial programmes of medical, hospital, dental, pharmaceutical and nursing benefits.[4] The inability of the provinces to finance health insurance schemes led to federal involvement and made health care a national political issue. The federal government realized that modern science had made medicine more complicated, specialized and expensive. There

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[3] For a presentation of government responses to these demands and the different proposals of the federal and provincial governments, see Canada, Dominion-Provincial Conference, Proceedings, 1945 - 46, (Ottawa: King's Printer, 1946).

[4] Ibid.

was a consequent necessity to adapt professional education to the changing requirements of society.[5] The initiatives of the private groups of several provinces, which provided health care services were based on the acceptance of these premises.

The health care institutions of the provinces, especially community hospitals, and their health education institutions, especially the medical schools, were thus directed to meet the demands for highly specialized health care and highly specialized education. The ever-increasing need for sophisticated facilities, technical equipment, and specialized personnel became a problem of national issue in the sense that Canadians demanded a national minimum standard.

The several private institutions within the provinces were soon swamped by the heavy financial burden imposed by this system of health care. Privately financed hospitals and health schools could not keep pace with the growing demand for expensive facilities, equipment and specialized personnel. Provincial governments were forced to support these institutions financially at ever-expanding rates. Large community hospitals and university schools became the recipients of significant

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[5] Further details could be found in J. A. MacFarlane, Medical Education in Canada. A study prepared for the Royal Commission on Health Services (Ottawa: Queen's Printer, 1964). See also, Bernard R. Blishen, Doctors and Doctrines, (Toronto: University of Toronto Press, 1969), chaps. 2-5.

outlays of public monies. Subsequently, and not unexpectedly, there were demands that these institutions and these services should become more accessible to the public, given the public support provided them.

These developments occurred in the context of a federal system where the national government had access to the greatest sources of public revenues, while provincial governments had the major sources of legislative authority for both health and health education. At the same time, the demands were for a common kind of health care, that is, not differentiated by various provincial or local interpretations, but where, at the same time, control over the dominant professional group, the doctors rested with provincial governments and provincial professional authorities. There was, on the one hand, a national government capable of providing the needed financial resources, a demand for government assistance to a policy field now viewed as one in which the national standards of quality ought to apply. Yet, on the other hand, there remained the original division of legislative powers and a professional community of health specialists whose "self-regulatory powers and educational efforts were provincially, not nationally based".[6]

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[6] A description and analysis of the self-regulatory powers of the professions in the province of Ontario is J. W. Grove, Organized Medicine in Ontario. A study for the Committee on the Healing Arts (Toronto: Queen's Printer, 1969), Chapter 4, pp. 8-11.

The obvious role of the federal government was to provide some of the financial resources for the principal provincial health services, initiate programmes in supporting areas, and to expand the programmes in its own field of jurisdiction. Thwarted by the provincial governments in its attempt to play a major role in revamping the health care system in the reconstruction period immediately following the Second World War, the federal government initiated a conditional grants programme in 1948.[7] This was the first comprehensive federal-provincial programme to improve and extend provincial health services. The programme comprised a system of federal grants to the provinces to: (a) develop their general public health services and public health research; (b) extend treatment services for mental illness, tuberculosis, cancer and veneral disease services, medical rehabilitation and maternal and child health; (c) support the build up of hospitals and other health facilities and (d) encourage the training of professional and technical health personnel. The federal government was then able to play a role in shaping the system by distributing monies to those individuals and groups in the provinces who were responsible for various aspects of health care. These aspects of health care included public health and research; mental

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[7] For an understanding of these grants, see, Donald V. Smiley, The Rowell-Sirois Report (Toronto: McClelland and Stewart, 1963), pp. 150 - 9. See also, D. V. Smiley, Conditional Grants and Canadian Federalism (Toronto: Canadian Tax Foundation, 1963).

health and infant and maternal care which were either too specialized or too costly for many of the provinces and their institutions to develop or to implement in a major way.[8] Through this scheme, the federal government was able to allocate financial resources to voluntary foundations, provincial departments of health, health care institutions, and even individual care researchers. Some of these monies were direct contributions, some required a complementary provincial contribution (the conditional grant or shared-cost programme), and some were given on a per capita basis to each of the provinces.

Through the grants for public health research, and along with grants for programmes administered by the Department of Veterans Affairs, the Defence Research Board, and the National Research Council, the federal government became the principal supporter of medical and health research in the country. It was able to play a role in the development of the health sciences in Canada. The modern conception of health care was one based on a scientific orientation.

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[8] C. Howard Shillington, The Road to Medicare in Canada (Toronto: Del Graphics, 1972), pp. 78-82.

This conception is readily seen in the federal government's support of health science activities and the impact of its policies in the field of medical education in Canada.[9] By the 1970's, the outcome of these initiatives was a federal role in all aspects of health care policy.

The two most publicized federal programmes are the 1957 and 1966 shared-cost programmes whereby the federal government allocated monies to the provinces to cover approximately half the cost of insured hospital and medical services. These services are commonly known as the hospital insurance and medical care programmes, now operating in each of the ten provinces and the two northern territories. The financial outlays involved in these two programmes constitute, in expenditure terms, the most important input of the federal government to health care policies in Canada.

The federal government is also able to play a significant policy role through the programmes of the Health Protection Branch of the Department of National Health and Welfare.[10] This Branch is responsible for evaluating, approving and regulating the drugs to

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[9] For further details, see, Blishen, Doctors and Doctrines, chap. 3. See also, J. A. MacFarlane, Medical Education in Canada, pp. 48-51.

[10] A description of the organization and functions of this Branch is found in Canada, Department of National Health and Welfare, Report, 1971-72 (Ottawa: Queen's Printer, 1973), pp.2-12.

be used by health personnel and those consumed by the public for the treatment of various disorders. The Health Protection Branch, therefore, becomes the nation's principal screening and control agency for what is or what is not acceptable medicine for the Canadian people. The federal government is, therefore, in a strong position to influence the nature and scope of an increasing critical dimension of health care policy.

In summary, then, the federal government, rather than the provincial governments, is by far the major supporter of health research in Canada. Its policies and programmes have a considerable impact on the structure and direction of health education, given the place of research activities and the scientist in the nation's health schools. There is a direct correlation between the scope, orientation and quality of the research supported by the federal programmes and the kind of health education found in Canada.

The overall role of the federal government in health policy can be summarized as follows: (a) "the financing of major service programmes of the provinces; (b) the medicines which play an important part in the prevention and treatment of ill-health and (c) the research

effort which is central to the education of health professionals and which is required for advances in the biomedical sciences, the basis of modern medicine and health care".[11]

The role of the federal government over the past quarter of a century illustrates very well the advantages of a federal system of public policy-making. Health care policies which promote the public welfare of Canadians have been formulated and legislated because, in part, there was a national parliament able to overcome both the doubts and dislikes of some provincial legislatures concerning the role of the state in providing for health care to all citizens, and, in some cases, the financial inabilities of some provinces to initiate such a role for their governments.[12] Provincial government approaches to health care have ranged from deep commitment and involvement to wait-and-see. The federal government has also

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[11] Peter Aucoin, "Federal Health Care Policy", in Issues in Canadian Public Policy, ed. A. Bruce Doern and V. Seymour Wilson (Toronto: MacMillan, 1974), p. 60. As will be shown in Chapter 5, pp. 163-164, new fiscal arrangements concluded between the federal government and the provinces in 1977, passed fiscal resources and administrative responsibility to the provinces after the first five-year cost-sharing arrangement expired in 1976.

[12] For a comprehensive analysis of how Canada's governments view Medical Insurance Schemes, see, "Submissions to the Royal Commission on Health Services by the Provinces" between September 1961 and March 1964.

promoted the development of the health sciences which, by the very boundaries of research communities, would be a task almost impossible for individual provincial governments to perform efficiently on their own.

The Government of Manitoba became preoccupied with the expansion of health care, at the time of federally financed support for the health system, in order to make it more readily accessible to the public. Health care, like education in the same period, was regarded both by the public and government as essential and hence had political appeal. The medical system in Manitoba, prior to the introduction of medicare was one in which the dominant health professional groups controlled the system. It is essentially this system, the assumptions behind it, and the expansion of it through government funding, especially medicare, that is now being given renewed scrutiny and analysis. The factors which led finally to government intervention will be reviewed in the chapter that follows.

CHAPTER II

PRE-MEDICARE PERIOD IN MANITOBA

In this chapter a preliminary exploration of the pre-medicare period in Manitoba will be presented as background to the more intensive analysis of Manitoba's decision to enter the federal medicare plan.

In the years preceding and during the Second World War, there were abortive attempts in several of the provinces to pass health insurance legislation. As will be seen later, none of these acts was ever proclaimed. Consequently, the need for hospital insurance coverage during this period came to be filled through hospital-association-sponsored prepayment group plans or private commercial insurance.

At the end of World War II, sentiment began to crystallize for national action on comprehensive social security programmes, of which health insurance was an essential part. Public hearings, conducted by a House of Commons Select Committee on Social Security[1], and the wide publicity and discussion given to the British Report[2] by Sir William

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[1] For a comprehensive report on Social Security in Canada, see Leonard Marsh, Report on Social Security for Canada (Toronto: University of Toronto Press, 1975). See also, Special Committee on Social Security and Health Insurance. Report of the Advisory Committee on Health Insurance, by J. J. Heagarty, Chairman (Ottawa: King's Printer, 1943). See also, Canada, Parliament, Special Committee on Social Security, Minutes of Proceedings (Ottawa: King's Printer, 1944), pp. 365-379.

[2] For highlights of this Report, see, Great Britain, Social Insurance and Allied Services, Report, 1942, especially Part VI, pp. 154-170.

Beveridge on Social Security, had a tremendous influence on Canadian policy-makers. The wide discussion clearly demonstrated that the principles and design put forth by Beveridge - namely, a plan for nationalizing Britain's piecemeal system of insurances, had extensive applicability in Canada. However, the impossibility of simply importing the Beveridge system to Canada was clear. Canada, unlike Britain, was not a unitary state. Its federal system required the sorting out of jurisdictional responsibilities and the guarantee of appropriate fiscal capacity.

In 1941, at the regular annual meeting of the Dominion Council of Health,[3] the Minister of Pensions and National Health suggested that the subject of public health and medical care might be discussed with the object of assisting the provinces in formulating comprehensive health plans.[4] In addition to the regular membership of the Dominion Council of Health, representatives of the medical profession and voluntary health organizations were represented. Speaking later of

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[3] The Dominion Council of Health is an advisory body to the Minister, composed of the Deputy Minister of Health as Chairman, the Chief Medical Officer of each of the provinces, and a representative respectively of Labour, Agriculture and Women's Urban and Rural Organizations, and one Scientific Advisor. This council meets twice a year.

[4] MacKenzie, Report on Health Insurance to a Conference of Dominion Ministers and Deputy Ministers of Health, May 10-12 (Ottawa: Queen's Printer, 1944), p.4.

this meeting, the Minister of Pensions and National Health stated that, "the members expressed themselves as being sympathetic to the formulation of a plan of health insurance which would comprise preventative medicine and medical care".[5]

At the annual meeting of the Canadian Medical Association in 1942, the Deputy Minister of Pensions and National Health reported that considerable progress had been made in his department in drafting proposals and plans for health insurance. In September, the Deputy Minister suggested to the Canadian Medical Association that a committee be appointed to meet with himself and Dr. J. J. Heagarty, the Director of Public Health Services, to consider the draft proposals prior to their submission to Cabinet.[6] The Canadian Medical Association then formed a Committee on Health Insurance to assist Dr. Heagarty, Chairman of the Committee on Social Security, in the preparation of a tentative draft plan. In addition to assisting in the drafting of the proposals to be laid before the Minister, the Committee circulated among members of the

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[5] Ibid.

[6] For details see, "The position of the Canadian Medical Association on Health Insurance", Canadian Medical Association Journal, 47 (September 1942): 261-2.

Canadian Medical Association a questionnaire to ascertain the attitude of the profession on the principles[7] which had been drafted by the Association. Approximately 2500 replies to the questionnaire were received and indicated approval of the principles by 90 per cent of those replying.[8]

The next development in paving the way for health insurance in Canada was probably of greater importance than any other single event. On January 18 and 19, 1943, the General Council of the Canadian Medical Association met in a special conference in Ottawa and approved the principles of health insurance in the following resolutions: (a) The Canadian Medical Association approves the adoption of the principles of health insurance; (b) The Canadian Medical Association favours a plan of health insurance which will procure the development and provision of the highest standards of health services, preventive and curative, if such plan be fair both to the insured and to all those rendering the services.[9]

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[7] A list of the principles is found in the Report of the 73rd Annual Meeting of the Canadian Medical Association in Alberta. See, "Report of the Executive Committee", Canadian Medical Association Journal, 49 (September 1942): 4-5.

[8] Ibid, pp. 2-6.

[9] Further information is found in "The Report of the Committee on Economics: 74th Annual Meeting of the Canadian Medical Association", Canadian Medical Association Journal, 49 (September 1943): 20-21.

Health insurance in Canada became an issue of national governmental policy during the Liberal administration of W. L. MacKenzie King, when the Governor-General in the speech to the throne, opening the 1943 session of Parliament stated that:

> "my ministers believe that a comprehensive national scheme of social insurance should be worked out at once which will constitute a charter of social security for the whole of Canada. The government accordingly proposes to recommend the early appointment of a select committee to examine and report on the most practicable measures on social insurance, and the steps which will be required to ensure their inclusion in a national plan. Among matters which will be referred to this committee for study and consideration will be the establishment of a national system of health insurance." [10]

Five years later Prime Minister W. L. MacKenzie King announced in the House of Commons that his Government had, "decided to proceed with a substantial health programme at the present session." [11] The programme represented, he stated, first stages in the development of a comprehensive health insurance plan for all Canada.

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[10] Canada, Parliament, House of Commons Debates, Vol. I (28 January 1943), p. 2. Henceforth cited as Commons Debates.

[11] Commons Debates, Vol. I (14 May 1948), p. 3932.

In order to obtain the views of provincial representatives on the revised proposals,[12] a conference of Federal and Provincial Ministers and Deputy Ministers of Health was held in Ottawa on May 10-12, 1944.[13] The House of Commons Special Committee on Social Security took the revised proposals under consideration, heard representatives from a number of organizations, and on July 29, 1944 presented its Third Report to the House of Commons.[14] The committee recommended that the bill be referred to a Federal-Provincial Conference for consideration of its general principles as expressed in its various clauses and of the financial arrangements involved.[15]

The period between the 1943 and the 1948 announcements was marked by the appointment of special health insurance committees of the Cabinet, select committees of the House of Commons, a national election, and a Dominion-Provincial conference at which lack of agreement between the Federal Government on the one hand and certain of the provinces on the other as to the respective fields

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[12] For a summary of the original proposals to the House of Commons Select Committee in 1943, see Leonard Marsh, Report on Social Security for Canada, 1975.

[13] For details of this conference, see, Canada, Parliament, Dominion-Provincial Conference on Reconstruction: Proposals of the Government of Canada (Ottawa: King's Printer, August 1945), p. 30.

[14] For details of this report on the Special Committee on Social Security, see, Commons Debates, Vol. VI (29 January 1944), p. 5573. See also, Canada, Dominion-Provincial Conference, 1945, pp. 43-44.

[15] Canada, Parliament, Special Committee on Social Security, Minutes of Proceedings (Ottawa: King's Printer, July 27, 1944), p. 1.

of taxation which each should occupy, precluded the inauguration of a full scale health insurance programme. Speaking specifically on this latter point, the Prime Minister said,

> "The Government has reached the conclusion that lack of agreement with certain provinces should no longer be allowed to stand in the way of a further immediate advance in the field of public health."[16]

Thus, in 1948, health insurance legislation was still absent from the statutes of Canada, but the commitment was there and the basic foundation on which the edifice of health insurance could be reached was being laid. How soon the final stage would be reached could not be foretold, but with the goal in sight, one may look back over a long and intermittent development of health insurance from embryonic idea to social policy.

With the end of the war, the attention of the Canadian people and their governments turned to the task of reconstruction. Toward this end, the Federal Government called a Federal-Provincial Conference on Reconstruction in August 1945. In its proposals submitted for consideration by the provinces, the Federal Government stated that its objectives were "high and stable employment and income and a

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16 Commons Debates, Vol. I (14 May, 1948) p. 3933.

greater sense of public responsibility for individual economic security and welfare."[17] The Government also stated that it had clear and definite views of how these objectives could be obtained, the most important being, "to provide, on the basis of smaller regular payments against large and uncertain individual risks, for such hazards and disabilities as unemployment, sickness and old age."[18]

There were changes made in the health insurance proposals at the request of the Ministers of Health meeting at a conference in 1944 in Ottawa. Views were put forward by several provincial Ministers of Health which appeared to have the support of most, if not all of the provinces. These indicated their strong desire that health insurance should be proceeded with by stages and that any scheme adopted should be flexible enough to permit the provinces to build on the varying services which each was already offering.

The Federal Government made four specific proposals: (1) A grant for planning and organization - a grant of $620,000 was to be divided among all the provinces for the purpose of the

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[17] Canada, Parliament, Proposals of the Government of Canada on Post War Reconstruction (August 1945), p. 7.

[18] Ibid. p. 8.

preparation of provincial health insurance plans to be submitted to the Federal Government for approval within eighteen months; (2) The health insurance proposals - the financial contributions by the Federal Government were attached to a proposed programme to be adopted in progressive stages. The first stage included a general practitioner service, hospital care, and a visiting nursing service. The federal government's contribution to the cost of each benefit under provincial health insurance plans was to be (a) a basic grant of one-fifth of the estimated cost of each service and (b) half the additional actual cost incurred by each Provincial Government in providing each benefit up to a stated maximum which would reach $12.96 per person when the complete programme was in operation; (3) Public Health Grants - These were similar to those proposed earlier, differing only in two respects: they were not to be conditional upon the adoption of health insurance by a province and they were substantially increased in amount; (4) The financial assistance to the provinces for the construction of hospitals - it was recognized that the provision of complete health insurance services would require a considerable extension in hospital facilities throughout the country and to this end the federal

government proposed to provide low-interest loans to the provincial governments.[19]

These proposals represented a substantial change in the federal position concerning the inauguration of a national health insurance programme. Gone was the principle that the provinces could qualify for federal assistance only through a comprehensive health insurance programme and accepted instead was the principle that a province could qualify simply by introducing health insurance services by gradual stages. Secondly, the Federal Government would raise the finances only through the income tax collection procedure. No model act was drafted and the only stipulation was that each provincial plan must be satisfactory to the Governor-in-Council. Provinces were completely free to decide whether administration was to be under an independent commission or under the Department of Health. The Federal Government recognized its responsibility for a financial contribution to improved health standards without reference to the more controversial issue of whether or not a province must introduce a health insurance programme. The inadequacy of the existing facilities to meet health

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[19] Shillington, The Road to Medicare in Canada, p. 31. See also, M. G. Taylor, "The Saskatchewan Hospital Service Plan" (unpublished PhD. dissertation, University of California, 1949), p. 39.

needs when the economic barrier to demands for health care would be removed was recognized by the Federal Government proposal for loans to be made available for hospital construction.

These proposals were submitted to the Federal-Provincial Conference which met in August 1945 and reconvened in April 1946.[20] Unfortunately, the discussions of the Conference diverted from the theme of reconstruction to the contentious matter of tax rental arrangements. Failure to arrive at an agreement on these federal-provincial financial arrangements effectively precluded the adoption of the package of proposals made by the Federal Government, including its far-reaching proposals for social security.

Rebuffed in its plan to implement sweeping change, the Federal Government decided in 1948 to proceed on a piecemeal basis with part of its programme. The Prime Minister announced that, notwithstanding the lack of agreement in certain provinces, the Government would proceed with a substantial health programme during that year.[21] What was thereupon proposed was essentially the system of health grants previously outlined. The Health Survey

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[20] For al elaboration of these proposals see, Canada, Dominion-Provincial Conference, Proceedings, 1945 - 46 (Ottawa: King's Printer, 1946).

[21] Commons Debates, Vol. IV (14 May, 1948), p. 3932.

Grants, as they were known, were to assist the provinces in setting up the machinery to ensure they were used effectively, and in planning the extension of hospital accommodation and the proper organization of hospital and medicare insurance.[22]

The grant was not to be conditional upon provincial implementation of health insurance within any specified time, as had been true of the original grants proposed in August 1945. The second change was the elimination of the grant for civilian blind since legislation making more adequate provision for blind persons had been passed at the 1947 session of parliament. The third and most significant change was the addition of a grant of $13,000,000 a year for hospital construction, to be continued over a period of five years. This was to be a matching grant of $1,000 per bed for hospitals providing care for the chronically ill. If all provinces were able to match the total grant under the conditions of the formula, the total number of the beds which would result during the five year period would be between 50,000 and 65,000.[23]

Within the next few months, all the provinces announced their intention to participate in the Federal Government's Health Grants Programme. Speculation continued, however, over whether the

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[22] Ibid, p. 3933.

[23] Taylor, "The Saskatchewan Hospital Services Plan", p. 103.

introduction of this programme for expansion of facilities meant that health insurance was to be postponed for another five years, or whether political considerations would hasten its earlier introduction. There is no tangible evidence pointing one way or the other. In the meantime, daily announcements were made in Ottawa of the progress of utilization of Health Grants.

A further Federal-Provincial Conference was called in 1950 to review developments which arose from the federal health grants established earlier. The Conference also discussed the nationwide Sickness Survey which was being undertaken by the provinces with the cooperation of the Department of National Health and Welfare and the Dominion Bureau of Statistics.

By the end of 1952 all provincial reports on the survey grants had been submitted to the federal government, except that of Newfoundland, which had only come into Confederation in 1949. While they varied in content, they did provide useful information regarding the development of health programmes.

The evidence gathered from five years of operation indicated the value of the grants and as a result three new grants were added in 1953, namely, (1) The Child and Maternal Health Grant; (2) The Medical Rehabilitation Grant and (3) The Laboratory and Radiological Services Grant. The Federal Government was again committed for another five year period as a result of these grants.

Growing provincial interest in the fifties was directed more toward a national hospital insurance scheme rather than a medical care plan as a priority. The Liberal government of St. Laurent had apparently indicated that once a majority of provinces requested such a plan, it would be implemented.[24] In 1957 Bill 320 was introduced and passed in Parliament by the Conservative Government of the Honourable John Diefenbaker. Under The Hospital Insurance and Diagnostic Services Act, 1957, all provinces eventually agreed by 1961 to provide hospital insurance coverage to their populations. The factors that contributed to the decision to proceed with a national hospital insurance programme and the terms of agreement between the Federal and Provincial Governments have been fully recorded elsewhere.[25] Briefly, The Act provided federal financial assistance up to half the cost of provincial hospital plans that made prepaid coverage universally available to all residents.

A national medical care insurance plan was to follow in 1966, but first an examination of the developments in the Province of Manitoba up to 1958 will be presented to illustrate the background to the birth of a medicare plan in Manitoba.

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[24] Shillington, <u>The Road to Medicare in Canada.</u> p. 81.

[25] <u>Hall Commission,</u> Vol. I. pp. 410 - 413.

In the evolution of hospital prepayment in Manitoba, there were two main streams: the one based on voluntary action and culminating in the Blue Cross Plans and Commerical insurance which by 1958 had enrolled 403,000[26] Manitobans; the other based on municipal and later on provincial government services.

The voluntary approaches to the problem in Manitoba took a variety of forms, including check-off systems in mining and lumbering towns and the sale of hospital tickets by individual hospitals. The plight of the hospitals during the depression led to a study of the Blue Cross Movement in the United States and in 1938 the first such plan was organized in Manitoba. Contracts were sold to the public in January, 1939.

Considering the modest beginnings of voluntary hospital insurance, the Blue Cross Movement was quite successful. Yet, even when supplemented by the aggressive merchandising of commercial insurance, only the highly industrialized Province of Ontario could bring the advantages of prepayment to as many as two-thirds of its citizens,[28] the rest of the province falling short of this percentage

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[26] Hall Commission, Vol. I, p. 386.

[27] Ibid.

[28] The population of Ontario in 1941 when the Blue Cross Movement was established was 3,787,655. This information is obtained from Canada, Bureau of Statistics: Census of Canada 1958 (Ottawa: Queen's Printer, 1961), p. 1.

of coverage. There were only 15,000[29] participants insured in Manitoba by 1941, out of a population of 729,744.[30] By the end of 1957, Manitoba Blue Cross had enrolled 403,000[31] participants. Thus, while Blue Cross proved the value of prepaid insurance, it also illustrated the drawback of private insurance whose advantage did not extend to all citizens.[32] Both its strength and deficiencies provided impetus for a public programme.

The second stream of development was the action taken by groups of people in using their municipal government or organization as the financial and administrative base for hospital programmes. The sparse settlement in the plains area of Manitoba and the absence of wealthy philanthropists to spark hospital construction or meet hospital operating deficits dictated action through the established agencies of local government. Indigent persons were treated in established general voluntary or municipal hospitals. Two major consequences followed from this. First, all hospitals had long been accustomed to receiving provincial and municipal governmental aid, invariably less than required, in caring for these patients. In fact, banding together to negotiate with the provincial treasurer served as an important rallying point in the establishment of hospital associations. Conversely, it also meant that

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[29] Hall Commission, Vol. 1. p. 386.

[30] Canada, Bureau of Statistics: Census of Canada 1941 (Ottawa: King's Printer, 1945), p. 3.

[31] Hall Commission, Vol. 1., p. 386.

[32] For further details, see, Hall Commission, Vol. 1. ch. 18.

the provincial government became involved in financial aid to hospitals and thereby became concerned with their general financing.[33] The second result was that municipalities found that from the responsibility of levying taxes to build facilities and carrying out the Elizabethan concept of responsibility for the 'sick poor', it was a relatively easy and logical step to increase the tax levy and to pay the hospital bills for all residents property owners. There were five municipal districts with eighteen doctors[34] in Manitoba in 1950.

It is a long distance from municipal plans to a nationwide programme, and it took more than twenty-five years for the way to be traversed. Although the introduction of the British Health Insurance Act of 1911[35] produced wide discussion of the subject in Canada, it was not until 1942 that the proposal for health insurance began to gather force and direction in Manitoba. The problem of providing the economic base for the adequate provision of health services became sufficiently important to warrant the attention of the Government of Manitoba on two separate occasions. The first

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[33] M. G. Taylor, "Canada's Programme of Prepaid Hospital Care", Journal of American Hospital Association, 35 (September 1961): 44.

[34] Manitoba, Legislative Assembly, Journals, Vol. 66, 5th Session (25 April 1932). p. 190. See also, Hall Commission, Vol. I, p. 386.

[35] Shillington, The Road to Medicare in Canada, p. 9.

of these two periods occurred during the years of the depression and the second followed the announcement of the Federal Government in 1945.

The depression increased alarmingly the number of people who could pay nothing whatever for medical care and substantially reduced the ability of newcomers to pay for medical and hospital services. With the enlargement of relief rolls, the ability of organized municipalities to pay for medical care of indigents declined to the vanishing point.

Spurred mainly by the growing seriousness of these conditions, a resolution was presented to the 1931 session of the Legislature[36] stating that the reluctance of the people to seek medical services and hospital facilities was largely due to the fear of inability to pay. Further, since health was considered a matter of paramount importance not only to the individual but to the state, the Minister of Public Health was requested to make a departmental inquiry and report to the Legislature.[37] The report should cover preventive medicine, the use

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[36] Manitoba, Legislative Assembly, Journals, Vol. 65, 4th session (31 March 1931), p. 248. This resolution was introduced by a private member during the Liberal-Progressive Conservative Government of Premier J. Bracken. For details, see, Manitoba, Legislative Assembly, Medical Services and Hospital Facilities, Hansard Scrap Book, 1931.

[37] Details of the inquiry are found in Manitoba, Legislative Assembly, Journals, Vol. 65, 4th session (31 March 1931), p. 249.

of municipalities as the economic and administrative base for the provision of health services, and provision for greater availability of diagnostic and treatment services. It was further resolved that following the preparation of this report, there would be appointed a special select committee of the Legislature to cooperate with the Minister of Public Health in the formulation of a comprehensive public health scheme with a view to providing more efficient and economical public health services.

The Committee was appointed and its report was presented to the Legislature during the 1932 session.[38] The principal finding of the Committee was "that the cost of illness should be provided for in advance of illness and the cost should be so distributed that it bears equitably upon all."[39] The Committee recommended the extension of preventive services, and, in the rural areas, the adoption of the Municipal-Doctor Plan. It also approved the expansion of municipal hospitals but recommended that the Province be divided into hospital areas and that there should be a Provincial Hospital Board to supervise hospitals.

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[38] Manitoba, Legislative Assembly, Journals, Vol. 66, 5th session (25 April 1932), p. 185.

[39] Ibid, p. 187.

For the urban areas, the Committee believed that health insurance appeared to be a logical and fair method of providing for illness in advance. The Committee was also concerned about the maldistribution and general lack of diagnostic facilities, especially in rural areas. It also suggested that, at a few strategic points diagnostic clinics should be established to bring to rural areas the advantages now confined and restricted to urban centres. The Committee then recommended that a second commission be appointed by the Lieutenant-Governor-in-Council to consider the health needs of the province as a whole and to formulate a plan on a sound actuarial basis whereby health services would be available to every resident of the province at a reasonable cost, which should be provided for in advance and distributed equitably.[40]

This second commission was never appointed and no further action was taken in the Provincial Legislature to implement proposals concerning the use of the municipalities as an economic and administrative base and health insurance in the cities. Health insurance became a live issue again as a result of the Federal Government's action in 1943 and 1944.

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[40] Ibid, pp. 189, 192.

Recognizing a widespread demand for a method of prepaying the cost of health services, the Manitoba Hospital Association was incorporated in 1938 as the Manitoba Hospital Services Association,[41] and established in that year the first Blue Cross in Canada.

A further development of voluntary medical care occurred in 1942. In order to demonstrate to the people of Manitoba that medical coverage could be obtained satisfactorily without government interference and regulations,[42] the Manitoba College of Physicians and Surgeons, the Manitoba Medical Association, and the Winnipeg Medical Society cooperated in the establishment of a medical profession-controlled medicare plan.[43] Within a meagre budget the profession undertook responsibility for the success of the experiment and the absorption of deficits in the operation of the project. The rationale for this action was to complement and work through the Manitoba Blue Cross Plan. Only members of the Blue Cross Plan could belong to the Medical Service. The Blue Cross Plan administered the medical plan for the Manitoba Medical Service. In addition to the restriction to members of the Blue Cross Plan, only individuals with an income of less than $1,800 and married persons with an income of less than $2,400 were

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[41] Manitoba,Statutes, Manitoba Hospital Services Association, 1938, 76-77, Ch. 20.

[42] A. Hollenberg, "The Manitoba Medical Service", Canadian Medical Association Journal, 53 (September 1945): 289-290.

[43] Manitoba,Statutes, An Act to Incorporate Manitoba Medical Service, 1942, 104-105, ch. 41. It should however, be noted that a doctor-sponsored plan for indigent patients was formulated as far back as 1930. The first contracts were sold to the public in 1944.

permitted to enroll. In general, the experience of the plan was not satisfactory since doctors were required to accept payments of between 50 and 60 per cent of their regular fee schedule in order to keep the plan solvent.

In 1945, the Minister of Health, Mr. Ivan Schultz, introduced, and the Legislature subsequently passed, The Health Services Act.[44] This Act was based on a plan drafted within the Department after informal consultation with professional groups.[45] The plan was based on four principles: (1) The establishment of a province-wide health service based on full-time local health units. The cost of this programme was estimated to be approximately $1.00 per person per year to be shared one-third by the municipality, and two-thirds by the provincial government; (2) The establishment of diagnostic centres in hospitals, both rural and urban, and the provision of necessary diagnostic tests required by any patient free of charge; (3) The provision of a general practitioner service on a prepaid basis; (4) The establishment of adequate hospital facilities based on a province-wide system of hospital areas.[46]

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[44] Manitoba, Statutes, Health Services Act, 1945, 92-115, ch. 22.

[45] For details of the plan see, Ivan Schultz, "Manitoba Outlines a Health Plan", Canadian Medical Association Journal, 52 (June 1945): 617-618.

[46] For details see, Manitoba, Statutes, Health Services Act, 1942, 93, ch. 22.

For the purpose of administering the Act, an advisory Commission of eleven members was established to work with the Department of Health and Public Welfare. The members of the Commission were chosen as follows: three from the Manitoba Division of the Canadian Medical Association; three from the Union of Manitoba Municipalities; one from the Medical Faculty of the University of Manitoba, and three nominated by the Minister of Health.[47]

While the position of the Commission was mainly advisory, it was provided that no regulation made under the Act should have force or effect until it had been approved by the Commission. As the Minister pointed out in an address following the passage of the Act, the plan envisioned by the Government was intended to form an integral part of and depend for its complete implementation upon the plan for health insurance to be adopted by the Federal Government.

As a result of the 1945 Federal-Provincial Conference then underway, the federal government was prepared to implement the first stage of a national health insurance scheme. The conference did not come to a successful conclusion because the provinces of Quebec and Ontario refused to enter the pact. The plan was, therefore, not implemented.

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[47] Ibid, p. 94

The economics of providing health care, especially to the poor, was a problem in Manitoba. The foundation had been laid by the Blue Cross Plan with sound principles and effective operating methods even though it did not cover the total population. The Hospital Construction Grant and other health grants had helped as well by meeting their 1948 objectives.

While due in part to legal difficulties, it was also because of the needs in local areas, and the necessity to find solutions to existing problems of municipal and provincial governments, that we find the first experimental steps in public expenditure toward prepaid health services being developed at the provincial rather than at the federal level of government. When the Health Survey Report was released in 1953, it indicated that one recommendation was very significant to Manitoba. It said that,

> "In any plan of prepaid medical and hospital care, use should be made as far as possible, of existing non-profit voluntary agencies in these fields, and that adequate representation in the administration be given to those responsible for providing the funds to operate the plan."[48]

In 1955 the Manitoba Legislature passed a new Act to amend The Health Services Act in order to allow any municipal corporation to enroll all or any group of residents in the municipality as subscribers of the Manitoba Medical Service.

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48 Shillington, The Road to Medicare in Canada, p. 83.

Greater demands by the hospitals and the public for increased hospital grants were made on the provincial government and the municipalities as the voluntary prepayment and commercial insurance was inadequate. Prepaid medical services were available to the citizens of Manitoba through the Manitoba Medical Service. The plan was available to any person able to pay the premiums. It provided comprehensive coverage for medical services for 400,000 Manitobans while approximately 350,000 had no coverage.[49]

At the 1955 Federal-Provincial Conference this issue was predominant and resulted in agreement for a universal, comprehensive programme to meet the needs of the hospitals and the public. The period between 1955 and 1958 was one of planning and expansion of existing facilities to insure the most effective use of the other health grants proposed in 1948. On July 1, 1958, the Manitoba Government inaugurated The Hospital Services Insurance Act, pursuant to Agreement entered into with the federal government and in accordance with provincial legislation. This Act established the Manitoba Hospital Services Plan. The plan has universal application to all residents of Manitoba, and the benefits are available to all residents on equal terms and conditions.

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[49] See, Government of Manitoba's brief to the Hall Commission, Health Services in Manitoba (Winnipeg: Queen's Printer, 1962) pp.9-12. See also, Charles H. Berry, "Voluntary Medical Insurance and Pre-Payment". A Study for the Royal Commission on Health Services (Ottawa: Queen's Printer, 1964) ch. 2.

While the benefits of pre-paid hospital insurance were now available to Manitobans, they faced the risk of staggering medical bills. Given that in Manitoba as well as in the other provinces, it was the poor, the aged and the ill who had the greatest difficulty in meeting medical expenses, some groups such as the Health Insurance Association and the Canadian Medical Association argued that any government schemes should concentrate on meeting the needs of those groups, and that the needs of the majority of Canadians should be met through the existing non-governmental schemes. The Hall Commission, on whose findings the provisions of the Medicare Act were based, examined this proposal in some detail. Their conclusion was that given an average expenditure on health services of some $350 per family in Canada in 1962, and accepting a figure of 5 per cent as the minimum a consumer should reasonably allocate to health services, then all below an income of $2,000 a year would be entitled to governmental assistance. As this amounted to over half the population in 1962, 'means testing' was ruled out on administrative grounds.[50]

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[50] Hall Commission, Vol. I. pp. 734-739.

The point to be made here is that these figures show that financing medical expenses was a problem for not only Manitobans, but for the majority of Canadians.

We can conclude from this review that the inability of many people to meet the cost of medical services without hardship was a social problem not only in Manitoba but in Canada prior to the passing of the Medical Care Act. Although the inadequacy of the arrangements to pay for medical services was only one aspect of the whole question of access to and availability of health care, nevertheless, it was a crucial aspect. In the case of health care, inability to pay for medical care, or hardship caused through the need to pay, had been the situation for many Manitobans throughout the twentieth century. However, the conviction that this was an issue on which the government should act took many years to develop, and was the result of a wide range of pressures and events.

In this chapter an attempt has been made to trace the development of medical insurance in Manitoba from its earliest beginnings through pay roll deduction plans on to hospital-sponsored prepayment plans and into comprehensive government-sponsored hospital programmes for the total population.

An example of voluntary health insurance, the Blue Cross Movement was cited as a pioneer in Manitoba. Medical co-ops - that is, consumer-sponsored plans - were also briefly discussed. Public health insurance was also reviewed. Municipal doctor services were used in Manitoba to induce doctors to settle in rural areas. Manitoba passed a Health Services Act in 1945.

The 1955 Federal-Provincial Conference dealt with hospital insurance as an important issue. It led to formulation, in 1957, of a major break-through in Federal-Provincial health legislation - the Hospital Insurance and Diagnostic Services Act, under which by 1958, Manitoba, inaugurated her own programme. This did not mean health services were universal or comprehensive. About one-third of Manitobans lacked medical insurance. Medical and hospital care, represented only a part of the whole spectrum of health services. It became evident that a scheme on a national basis was the answer, with Federal-Provincial agreement on programmes to ensure the provision and distribution of the best possible care regardless of age, income or state of health. The factors which led finally to government intervention will be reviewed in the next chapter.

CHAPTER III

THE EVOLUTION OF MEDICARE IN MANITOBA IN RELATION TO THE FEDERAL MEDICARE PLAN

In this chapter we will examine the Federal Medical Care Act of 1966 and its principles. This will be followed by an examination of the provincial government's actions leading up to the enactment of the enabling medicare legislation to enter the federal plan.

The evolution toward a national medical care insurance programme, which spans over twenty years from 1948 to 1968, gave the federal and provincial governments ample opportunity to develop the infrastructures for the plan. Despite this, the introduction of medicare was carried out by each province in relation to its social, economic and political circumstances rather than as a single national plan. Since Saskatchewan introduced health insurance before the national plan, there was an opportunity for the federal government and other provincial governments to learn from its experiences.

The Medical Care Act, 1966-67 was passed by the Canadian Parliament in December 1966, by a vote of 177 to 2, and after a year's delay, came into operation on July 1, 1968.[1] It had been introducted in the Commons,

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[1] For details of the Act, see, Canada, Laws, Statutes, etc., <u>Medical Care Act</u>, 1966-67, 14 & 15 Eliz. 2, ch. 64. See also, Canada, Laws, Statutes, etc., <u>Medical Care Act</u>, 1970, 18 & 19 Eliz. 2, ch. M-8. See also, Geofrey Stevens, "Commons Gives Final Approval to Medicare with Only Two Socreds Dissenting" <u>Toronto Globe and Mail</u>, December 9, 1966. The reasons for delay are discussed later in this chapter.

by the Honourable A. J. MacEachen, Minister of National Health and Welfare in Prime Minister Lester B. Pearson's Liberal Government. Political consensus involving the Liberals, who as the minority government in power had introduced the bill in July, the Progressive Conservatives, and the New Democratic Party had followed periods of extended debate. The bill was based on the proposals which the Prime Minister had put to the Provincial Premiers at a Federal-Provincial Conference in July 1965.[2] Despite extensive consultations with the provinces both before and after the 1965 conference, only two provinces, Saskatchewan and British Columbia supported the bill and entered the plan immediately. With varying degrees of reluctance, the remaining provinces gradually overcame their objections to the Act, and on January 1, 1971, with the entry of New Brunswick, all ten provinces had become participants in the plan. As of April 1, 1972, all provinces and territories had entered the federal programme.

The Medical Care Act is a measure which authorizes the payment of contributions by the Government of Canada toward the cost of insured medical care services offered by provinces under provincial medical care insurance plans.[3] By transferring federal funds to the

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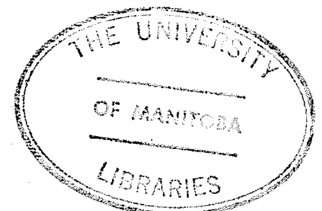
[2] For details of this conference, see, Canada, Federal-Provincial Conference, July 19-22, Proceedings (Ottawa: Queen's Printer, 1968).

[3] Commons Debates, Vol. VIII (13 October 1966), p. 8610.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provinces, the Act was intended to close the gap described earlier, between the federal government's superior financial power and the acknowledged constitutional primacy of the provinces within the health field.

Devised in response to the incongruence of legislative and financial powers as between each level of government, the Medical Care Act was also intended to introduce a certain form of medical care insurance across Canada. Using the lure of additional funds, subject to certain conditions, the Federal Government was virtually ensuring that a certain approach to medical care insurance would be adopted in all provinces and territories of the country. The features of this approach were laid down in section 4 (1) of the Act.[4] No provincial medical care insurance plan could receive funds under the Act unless it satisfied the following criteria; (a) Comprehensive coverage - This meant that the insurance plan must provide coverage for all medically required services rendered by a physician or surgeon, without dollar limit or other limitations, provided there is medical need. Furthermore, the plan must be administered in such a way that it does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to insured services; that is, if there is a deterrent or

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[4] Canada, Medical Care Act 1966-67, ch. 64.

utilization fee, it must not actually deter a person from getting necessary care. The plan must include preventive and curative services which traditionally have been covered through the public sector such as medical care for patients in mental and tuberculosis hospitals. Although there is some discretion regarding what constitutes 'medically required services' (eg. family planning measures, plastic surgery) the vast majority of physician services must be covered; (b) Universal availability - The proposed insurance plan must be available to all eligible residents on equal terms and conditions and cover at least 95 per cent of the total eligible provincial population (the figure was 90 per cent for the first two years of operation). Hence, no discrimination is permitted on account of previous health, age, non-membership in a group, or other considerations; (c) Portability of benefits - The plan must provide coverage when an insured resident is temporarily absent from a province or when he is moving to another province that is part of the scheme; (d) Non-profit basis - The plan must be administered on a non-profit basis by a public authority that is accountable to the Provincial Government for its financial transactions.[5]

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[5] Canada, Department of National Health and Welfare, Review of Health Services in Canada, 1974, pp. 2-3. See also, Canada, Department of National Health and Welfare, Overview of the Canadian Health System, (Report prepared for the Sun Valley Forum), August 1974, pp. 68 - 73.

It can be seen that although certain aspects of health insurance schemes are left to the discretion of the provinces (such as administrative arrangements for the operations of the plans and the method of financing, whether by premiums, sales tax or other provincial revenues), the degree of flexibility allowed the provinces in respect to health care insurance policy is severely limited. The Medical Care Act, in effect, introduced a policy of universal, comprehensive, portable, government-provided health insurance into Canada.

Apart from the criteria laid down for Provincial Government participation in the programme, The Medical Care Act contains certain other important provisions. First, The Act was limited to providing benefits rendered by a medical practitioner, which in practice meant physicians and surgeons and, in some circumstances, dental surgeons, but not paramedical personnel such as nurses.[6] Second, The Act laid down the basis on which contributions to the provinces should be calculated. The amount was 50 per cent of the per capita costs for the year of all insured services provided under the medical care insurance plans of participating provinces, multiplied by the number of insured persons in a particular province. It can be seen that there is a

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[6] The regulations were relaxed in 1975 to offer alternatives to higher cost services. Examples of such alternatives include home care, geriatric services, community health services, and ambulatory care. This point is also referred to again in Chapter 5 of this Thesis.

redistributive element in The Act which favours the less wealthy provinces, who spend less per capita on health services than do the other provinces. Third, it should be noted that The Act provided for a review of the amount and manner of federal contributions 'at least six months before the 31st day of March, 1973' (Section 8). On the basis of this provision, important changes in the financial arrangements related to The Act were proposed by the Government of Canada in 1973. Discussions with the provinces relating to these changes have recently reached an impasse which was not resolved until there was agreement in 1977 on the overall fiscal arrangements between the two levels of government.[7]

In introducing the Medical Care Bill into the House of Commons on July 15, 1966, the Minister of National Health and Welfare stated, "The Government of Canada believes that all Canadians should be able to obtain health services of high quality according to their need for such services and irrespective of their ability to pay."[8] The implication was that many Canadians were being deprived of medical care because of their inability to pay for services that were being offered.

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[7] This point is discussed in Chapter V, especially pp. 163-164.

[8] Commons Debates, Vol. VII (12 July 1966), p. 7545.

The Minister went on to suggest that existing approaches to health insurance were inadequate, ...

> "... the use of voluntary partial coverage plans and the use of partial coverage approaches will not meet the problem of health care in Canada ... Substantial numbers of families lack motivation to protect themselves against future costs through voluntary approaches to insurance regardless of the smallness of premiums required. For various reasons, certain low income persons are among those most unlikely to enroll on a voluntary basis."[9]

To what extent was the Minister correct in his understanding of the problems which his policy was designed to overcome? To answer this question, a brief examination of the nature and extent of insurance against medical costs which existed in Canada prior to 1966 will be presented.

Insurance against the costs of medical services had a long history in Canada prior to the passing of The Medical Care Act.[10] First, there were the profession-sponsored medical plans which emerged in the late 1930's in Ontario, and which later spread to other provinces. These plans were controlled by the medical profession, and by 1961 it was estimated that 4,848,000 Canadians had some form of coverage under these plans.[11]

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[9] Ibid, Vol. IX (25 October 1966), pp. 106-7.

[10] For a comprehensive account of the history of health insurance in Canada, see, Hall Commission, Vol. I, ch. 10.

[11] Ibid, p. 389. This figure includes Blue Cross Plans which had moved into the field of medical benefits as opposed to simply hospital insurance.

Secondly, there were the co-operative plans. These differed from the previous category in that it was the consumers rather than the providers of service who controlled the organization. A wide variety of co-operative plans had existed in Canada throughout the 1930's and 1940's, but some had been amalgamated with the profession-sponsored plans and others ran into financial difficulty. By the end of 1961 only 138,370 people in Canada were insured through co-operatives for medical and hospital benefits; 55,563 having group and 82,807 having individual contracts, representing a marked decline in this type of insurance.[12]

Thirdly, there were the insurance schemes provided through the commercial insurance companies. The types of insurance offered generally did not follow the principles of social insurance. The social insurance plans were compulsory prepayment plans designed to provide a mechanism by which people could save to meet the contingencies of life regardless of their health. Provincial Workmen's Compensation plans were established as early as the 1880's to meet the contingency of injury on the job. An Unemployment Insurance Plan was established in 1940 to meet the contingency of temporary unemployment,

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[12] Prior to the end of the year, non-group contracts accounted for 1.3 million or about 14 per cent of all persons covered. For a description of the different categories of insurance coverage, see, C. H. Berry, "Voluntary Medical Insurance and Prepayment", ch. 2.

and the Canada and Quebec Pension Plans were established in 1965 to provide a mechanism by which people could save for retirement whether by reason of age or disability.[13]

An analysis of these plans is however, beyond the competence of this study. In the main the benefits offered were indemnity benefits rather than service benefits; that is, they undertook to pay a stipulated amount on the occurrence of a specified contingency, such as a visit to the doctor. Moreover, premium schedules were established on the basis of the claims experiences of various groups, so that premiums for the aged or chronically sick, for example, were much higher than the average premiums. Despite these limitations, by 1961, 4,635,000 Canadians had some form of medical insurance through the commercial companies.[14]

On the basis of their review of health insurance schemes in Canada, the Hall Commission concluded that out of a total of 18.2 million Canadians

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[13] These programmes are analyzed in Canada, Office of the Minister of National Health and Welfare, Social Security (Ottawa: Queen's Printer, 1974).

[14] Hall Commission, Vol. I, p. 392. See also, Department of National Health and Welfare, Voluntary Health Insurance in Canada, 1955-56 (Ottawa: Queen's Printer, 1963), pp. 1-13. Their estimate of total Canadians covered by the scheme is 8,389,311 or 47.2 per cent of the total population which is slightly less than the Hall Commission figure.

in 1961, approximately "10.7 had some form of medical insurance or prepayment coverage."[15] This left over 7.4 million Canadians with no medical insurance whatever. Although by 1966 this figure of uninsured persons had dropped considerably, it was still estimated that over 20 per cent of Canadians had no cover against medical costs.[16] The adequacy of coverage for those who were insured also left much to be desired. Nearly three million people in 1961 only had limited benefits through the commercial insurance and prepayment plans. The variations in benefits between the different schemes often made it difficult for medical practitioners to determine the entitlements of their patients. In addition, there were marked variations in the premiums charged for private insurance coverage. Group rates were often lower than individual rates, and there were also inter-provincial differences in rates. Wide variations existed in the cost-benefit ratios of schemes offered by the same insurance carriers. It is reported that in 1965-67, insurance company premiums collected per dollar of benefit paid varied from about \$1.16 for the large insurance groups of Ontario to about \$1.89 for non-group coverage in Prince Edward Island.[17] The variations in benefits and inadequacy of coverage by the private insurance companies was a deciding factor in a province's adoption of the federal plan.

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[15] Hall Commission, Vol. I, p. 727.

[16] Canada, Department of National Health and Welfare, Overview of The Canadian Health Care System, p. 14.

[17] Hall Commission, Vol. I, p. 17.

In addition, there had been some movement toward government-operated insurance schemes in the provinces, particularly in the years prior to the Medical Care Act. It has already been mentioned that many people in Manitoba were unable to pay their hospital bills, especially during the depression years. A legislative committee was established in 1931 to look into the problem. This committee reported to the legislature in 1932, and recommended that assistance should be given to the municipal doctor plans and that a second committee should be appointed to investigate the feasibility of health insurance in the urban areas. This committee was never appointed, possibly because no public programmes larger than municipal doctor or hospital plans had been tried and proved to work in Canada at that time.

In 1945, as a result of the publicity given to the House of Commons Hearings in 1943 and 1944, the Manitoba Government passed The Health Services Act.[18] By 1946, free diagnostic out-patient services were introduced in a number of rural health units. There was no other aspect of the programme adopted until the National Hospital Insurance Programme in 1958, for which special legislation was passed.

Like most other Canadians, Manitobans were expecting that something would be done by their government. Their expectations were high

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[18] Ibid, p. 397.

when the Royal Commission Report on Health Services was produced on June 19, 1964.[19] The role of the various participants in the process of Manitoba's entry into the national plan will be discussed in Chapter IV.

The Government of Manitoba undertook a special study of the Hall Report, but indications are that the Conservative administration was content to leave medical insurance with the Manitoba Medical Service and private companies, provided satisfactory coverage was afforded.[20]

The Manitoba Government took every opportunity to escape a commitment to the federal medicare scheme. It entered the scheme only after events, both inside and outside of Manitoba, made it politically impossible to remain outside. As will be shown, developments left the government with little alternative but to implement a compulsory medical insurance programme for Manitobans. Evidence suggests that there were a number of occasions when the federal government wavered in its commitment to the medicare legislation. But, tactical blunders on the part of Manitoba doctors and the provincial government itself, plus the inability of the ten provincial governments to work together in overwhelming the federal government, contributed to making medicare a 'fait accompli' in Manitoba.

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[19] See Submissions by Premier Duff Roblin and Dr. George Johnson, Minister of Health for the Province of Manitoba to the Hall Commission (Winnipeg: Queen's Printer, January, 1962).

[20] Ibid, especially sections 24, 35, 44, 45, 50.

By 1966 with rising deficits and the need to increase taxes, the Roblin Government placed priority on curbing taxation. The government also emphasized that medicare was a matter of provincial jurisdiction. While the Premier placed priority on fiscal restraints, Manitoba made substantial gains in higher grants for schools, improved legal aid for indigents, compensation for crime victims, and protection of borrowers from harsh mortgage and credit contracts.[21] The Premier accepted the terms of the federal legislation, although he had strong reservations about the nature of the scheme and the alleged arbitrary pressure tactics used by the Federal government. The Premier said, "the Federal government had forced Manitoba into adopting a compulsory, prepaid plan".[22] He indicated that adoption of the federal medicare bill by the Senate had ruined Manitoba's chances of having a voluntary health insurance scheme. The Premier further said, "the provincial government will now present a bill instituting the compulsory plan at the current session of the Legislature."[23]

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[21] Saywell, Canadian Annual Review, 1966, p. 135.

[22] "Duff says compulsory plan forced on us by Ottawa," Winnipeg Tribune, 22 December, 1966, pp 1-2.

[23] Ibid. The provincial government had, however, opposed implementation of the plan at several earlier stages and in several forums.

In line with the Premier's pronouncement Health Minister Witney later told the Legislature that joining the federal plan under its terms and conditions was the only practical choice if Manitobans were to be provided with insurance against the costs of medical services regardless of age, health or financial circumstances.[24]

In response to the Minister's statement, Dr. Garth E. Mosher, President of the Manitoba Medical Association, criticized the government's compulsory medical insurance scheme. He said, "the government of Manitoba was not obligated to make the plan compulsory under the law. It was only necessary to get 90 per cent of the people enrolled."[25] But in examining the four criteria already mentioned, and in particular the percentage of insured residents required for federal contribution, it became obvious that Manitoba must introduce a compulsory plan. This became further evident when the province was not permitted to include in the quota of 90 per cent, those people already enrolled in the Manitoba Medical Service or private insurance companies, presumably because such plans were not operated by a public

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[24] Manitoba, Legislative Assembly, Legislative Debates, Vol. XIII (1967), pp. 1712-1716. Henceforth cited as Manitoba Debates.

[25] "Health plan flayed: Doctor lashes compulsory medicare scheme," Winnipeg Free Press, 15 March 1967, p. 4.

authority. This left the Manitoba Government almost no room to maneuver. The Manitoba Medical Association head insisted that there was "no justification and no valid reason for the prohibition against alternate coverage contained in the medicare legislation."[26] The Manitoba Legislature gave the medical care insurance legislation second reading approval in principle on April 24, 1967, by a vote of 44 - 2 although the majority of the members expressed strong reservations about the plan.[27] The bill was then sent to the Legislature's Law Amendment Committee for refinement.

At his appearance at the opening of the Committee's detailed consideration of the province's medicare bill, Dr. Mosher said the proposed compulsory legislation was a "good basic framework within which, with the goodwill of doctors, government and medicare corporations, an adequate medical services plan could be built."[28]

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[26] "Medics criticize medicare control," Winnipeg Tribune, 26 April 1967, p. 33.

[27] Manitoba Debates, Vol. XIII (1967), pp. 2853-2863. One Conservative member and one Social Credit member voted against the bill.

[28] The Winnipeg Tribune, 26 April, 1967.

He also told the Committee that additional coverage over a compulsory scheme would provide a 'safety valve' to the operation of medicare. It would alert the government to any widespread public dissatisfaction with medical service under the compulsory government operated plan. Why would Dr. Mosher, having earlier opposed the government's proposal, now commend Manitoba's enabling legislation to enter the federal medicare scheme? In a later interview, Dr. Mosher explained the Association's apparent change of position:

> "The opposition to the government proposal was in detail, not in general. The bill could probably have been improved in certain areas, but like all laws was really dependent on enlightened implementation and good will of all the parties to make it work properly. The Roblin administration also gave the Manitoba Medical Association ample opportunity to make input through its solicitors to the Legislative Council in the preparation of the wording of the statute. Every attempt was made to involve the Association within the limitations imposed by the political process. It was only fair that in view of this enlightened approach, that the profession not involve itself in political sniping at the government. Medicare was in general a proposition which the medical profession and its organizations had supported since the early 1930's. In addition, the medical profession had shown the way by establishing doctor-sponsored health plans throughout Canada to fill the gap in the interval left by government inaction. However, the technique of implementation of the programme, both at the Federal and Provincial level, was in some ways faulty, but we believe that running repairs could be made and with good will the scheme could be operated to the benefit of both doctors and patients in the

> province; this still is possible if political expediency could be divorced from the needs of the programme."[29]

There is no reason to question the sincerity of Dr. Mosher's statement since what is being said is that the Manitoba Medical Association was trying to achieve the introduction of the scheme on the best possible terms for the profession, having already lost the fight over the principle of the plan. The bill had already passed second reading, constituting approval in principle. By adopting a dogmatic ideological position, it was very unlikely the Manitoba Medical Association would have achieved their objectives. While there could have been other avenues open to the Manitoba Medical Association, fighting a losing battle with the government would not have been in their best interest. Another possible suggestion for the Manitoba Medical Association's failure to block the provincial legislation was that it reflected the increasing extent to which health care had been viewed by the government as a public issue and responsibility rather than the preserve of a professional group.[30] Medicare was a reflection of this change.

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[29] Verbatim record of author's interview with Dr. Mosher on 31 January, 1977.

[30] For an understanding of this shift in perception, see G. R. Weller, "The Politicization of Health Services in Canada" in Papers Presented at the Forty-Seventh Annual Meeting (Ottawa: Canadian Political Science Association, 1975), pp. 60 - 99.

On May 27, 1967, Bill 68 received final approval in the Manitoba Legislature. The Act was proclaimed on May 17, 1967,[31] but did not come into force until July 1, 1969. In accordance with Ottawa's principles, the compulsory medicare scheme would meet the 90 per cent enrolment figure, be portable from province to province, offer comprehensive coverage and be run by a publicly operated medical insurance corporation.[32]

While the medicare bill was being discussed in the legislature, it became evident that some form of government-doctor co-operation was required. Dr. Norman Corne, Chairman of the Manitoba Medical Service, announced a premium increase of between 12.5 to 18 per cent for subscribers effective July 1, 1967,[33] to cover fee increases for Manitoba doctors.

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[31] Manitoba, Statutes, An Act Respecting Insurance of Residents of the Province in Respect to the Cost of Medical Service, 1967, 185-210, ch. 36.

[32] The Manitoba Medical Services Insurance Corporation (M.M.S.I.C.) represented a variety of groups throughout the province. The Chairman was Dr. Tanner, former Executive member of the Manitoba Medical Association; Dr. R. E. Beamish, former Executive member of the Manitoba Medical Association, now with Great West Life; Dr. D. N. C. McIntyre, former Chairman of the Manitoba Medical Service (the doctor-operated non-profit medical insurance corporation) and Past President of the Manitoba Medical Association; Joseph James, Executive Secretary of the Manitoba Federation of Labour; A. J. Penner, Auto Dealer in Steinbach; C. F. Widow, Reeve of Pipestone Municipality and W. L. Palk, Lawyer.

[33] The Winnipeg Tribune, 29 April 1967, p. 1.

Since the provincial government had to take over the Manitoba Medical Service when medicare became a reality, the fee hike by the doctors was a move to improve their bargaining position when medicare would be introduced. The Manitoba Government, still hostile towards medicare, was hoping that the Federal Government would drop the scheme. Manitoba's enabling legislation to establish a compulsory scheme would consequently be nullified.

At the annual conference of provincial premiers on August 1 and 2, 1967, in Fredricton, Manitoba and other provincial governments renewed their medicare criticism of what Premier John Robarts of Ontario termed, "Ottawa's 'sleight-of-hand' invasion of provincial jurisdiction. They insisted that national medicare was being foisted on the provinces without adequate consultation and before they are ready for it."[34] Despite increasing provincial opposition, renewed pressures by the Canadian Medical Association, and a split within the Liberal Party, Prime Minister Pearson gave no indication that the bill would be amended. At a meeting of finance ministers on November 16 and 17, 1967, in Ottawa, all provinces indicated forcefully that they did not want the scheme forced upon them by

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[34] "Ontario cool to medicare," Winnipeg Free Press, 12 August 1967, p. 31.

Ottawa. In summing up the attitude of the provinces, Premier Roblin said:

> "You leave Manitoba no alternative but to fall in line with the terms of the Medicare Act. To do otherwise would be to permit the people of this province to be taxed by your government for a service they could not receive."[35]

What the Premier was saying, in effect, was that the provinces were being blackmailed to enter the scheme. It should be noted that this action was not unprecedented; many other shared cost programmes such as the Canada Assistance Plan, provided a strong financial inducement for provinces to participate. The plan would go ahead regardless and Manitoba citizens would be taxed to meet the costs. At the same time the provincial government suspended its negotiations for the takeover of the Manitoba Medical Service because of what it termed, "the uncertainty as to whether Ottawa will go ahead with the compulsory medicare scheme."[36]

Such uncertainty arose because of a rumoured split within the governing Liberal Party in Ottawa. The extent of the split within the Federal Liberal Party is difficult to determine and to document. The reasons for the opposition to the plan were apparently varied and only some of them can be mentioned here. Some ministers

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[35] The Winnipeg Tribune, 17 November 1967, p. 6.

[36] Ibid, 18 November 1967, p. 1.

argued that the medicare scheme should be deferred because their constituents opposed it. Mitchell Sharp and others opposed it because it would be additional charge on the overloaded federal and provincial budgets. There were others who thought the provinces would be defending their constitutional authority over health at a constitutional conference that was underway. Mr. Walter Gordon, the Liberal Finance Minister of the day was not, however, impressed by these arguments:

> "the policy had been adopted after due consideration; it was embodied in the law and it should not be tampered with. To make further retreat, would make everyone look ridiculous."[37]

Mr. Gordon was a close personal friend of Prime Minister Pearson and the Prime Minister recorded later that he was in sympathy with the views of his finance minister.[38] Opposed to this position was a group of ministers regarded as being on the right wing of the party, who were led by Mr. Mitchell Sharp, then Minister of Finance from 11 November 1965 to 20 April 1968.

While the federal government's intentions were uncertain, many liberal ministers felt that the government would not survive another postponement of medicare. For example, External Affairs Minister

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37 For further details, see Dennis Smith, Gentle Patriot: A political biography of Walter Gordon (Edmonton: Hurtig, 1973), pp. 339 - 340.

38 Lester B. Pearson, Mike: The memoirs of the Right Honourable Lester B. Pearson, 3 vols. (New York: Quadrangle Books, 1972-1975) 3: 84 - 90.

Paul Martin, who was acting Prime Minister while Mr. Pearson was in Britain from November 21 to 27, 1967, gave assurances after a cabinet meeting on November 22, 1967, that medical care would go ahead as scheduled.[39]

The Government of Manitoba's persistent opposition to the plan was affected by several factors. Medicare was not a top priority of Premier Roblin. This was a period when Manitoba was spending huge sums of money on other expensive programmes such as education, housing, highways, and the expenses were mounting.[40] The Premier was forced to introduce a 2 per cent sales tax in 1964.[41] Other increases in liquor, mining operations, tobacco, etc., were inevitable. The political unpopularity created by these measures induced the government to avoid a new costly programme. Premier Duff Roblin resigned as Premier of Manitoba to enter

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[39] Canadian News Facts, the indexed digest of Canadian current events, Vol. I, Dec. 4, 1967, No. 23, p. 181. See also, John Saywell, ed., Canadian Annual Review 1967 (Toronto: University of Toronto Press, 1968), pp. 385 - 8; The Winnipeg Tribune, 21 November 1967, p.1.

[40] Saywell, Canadian Annual Review 1964, p. 142.

[41] Ibid, p. 141.

federal politics on November 27, 1967 and was succeeded by W. C. Weir as the new Premier of Manitoba.[42] Weir, described by some as 'fiscally conservative' brought to office a traditional brand of conservatism, advocating a tighter fiscal policy to match expenditures with government revenues.[43] The new Premier would only increase government expenditures as the tax base expanded. Like his predecessor, Premier Weir shared the view that medicare should be delayed beyond the scheduled starting date of July 1, 1968. In reply to questions from reporters, Premier Weir stated:

> "we're still in limbo. We are actively considering Manitoba's position at the moment in light of changing economic conditions within the province and Canada."[44]

He went on to indicate that a final decision would be determined by the situation in Manitoba, but added, "of course, the actions of other governments will be considered."[45]

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[42] Saywell, Canadian Annual Review 1967, p. 153. See also, Canadian News Facts, 1967, p. 179.

[43] For an explanation of this line of thought, see Saywell, Canadian Annual Review 1967, p. 153. See also, Canadian News Facts, 1967, p. 179.

[44] 'Manitoba remains undecided,"The Winnipeg Tribune, 4 January 1968, p. 1. See also, Saywell, Canadian Annual Review 1968, p. 164.

[45] The Winnipeg Tribune, 4 January 1968, p. 1.

Internal dissension in his party and pressure from the Canadian Medical Association and the provinces did in fact, force Prime Minister Pearson to suggest, in January 1968, that the cabinet would take another look at the government's national medical care programme.[46] However, there was no indication the federal government was abandoning its commitment to the plan. The announcement on December 14, 1967 of Prime Minister Pearson's resignation and the leadership convention scheduled for April 6, 1968, may have given the anti-medicare forces renewed hope. The candidates for Mr. Pearson's job were split on the issue and faced with the delicate problem of maintaining cabinet solidarity and supporting the existing law. At a panel meeting of Liberal leadership candidates those who called for a second look at medicare were Transport Minister, Mr. Paul Hellyer, the Post Master-General, Mr. Eric Kierans, and the Finance Minister, Mr. Mitchell Sharp. The candidates in favour of medicare were, the Health Minister, Mr. Allan MacEachen, the External Affairs Minister,

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[46] "Medicare gets another look," The Winnipeg Tribune, 12 January, 1968, p. 1. See also, Saywell, Canadian Annual Review 1968, pp. 379 - 381.

Mr. Paul Martin, the Agricultural Minister, Mr. J. J. Greene, and the longshot candidate, Mr. Lloyd Henderson, the former mayor of Portage La Prairie, Manitoba.[47] The attitude of the eventual leader of the leadership race, P. E. Trudeau, toward immediate implementation was unclear.

Premier Weir took advantage of the split in the Liberal Party over medicare to announce that Manitoba would not participate in the federal medicare insurance plan for at least a year. This action was based on the speculation that the split might lead to a decision by the Federal Liberal Government to postpone or modify the implementation of the national scheme. At the same time the alleged split reinforced the Manitoba Premier's opposition to the scheme. The government's decision was contained in a telegram to Prime Minister Pearson, which stated:

> "Manitoba will insist that it get a proportionate share of any federal taxes imposed to pay for the plan, and we remain convinced that medical insurance should be available to all of our citizens regardless of their income level.

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[47] The Winnipeg Tribune, 15 January, 1968, pp. 1 - 2. See also, Canadian News Facts, 1967, pp. 185 and 194; Ibid, p. 13.

> Equally we remain convinced that the plan presented to us is not the most effective or most desirable method of achieving that goal. We will therefore defer participation for at least one year and make every effort to bring about those changes in the federal plan which we consider to be desirable."[48]

In the same telegram, the Premier indicated that Manitoba would be seeking a revised plan[49] more suited to the needs of Manitobans. It was also hinted that Manitoba might challenge the constitutionality of the federal plan, should the Liberal Government decide to proceed with it after a new leader had been selected. The hope was that, if an advocate of delay became Prime Minister, the federal medicare scheme might not only be postponed for a year but perhaps indefinitely.

On April 6, 1968, P. E. Trudeau was elected leader of the Liberal Party replacing Lester B. Pearson as Prime Minister

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[48] The Winnipeg Tribune, 2 February, 1968, pp. 1-2.

[49] Manitoba was seeking a revision which would have had residents pay the first $50 of their medical costs and 20 per cent of the costs after that up to a maximum of $100. No premiums would have been charged and persons requiring public assistance would have been exempt from partial payment. Canadian News Facts, 1968, p. 140.

of Canada on Monday, April 22nd.[50] Three days later, Mr. Trudeau announced that the country would go to the polls in a general election, Tuesday, June 25, 1968.[51] Mr. Trudeau's election platforms, policies and strategies were various,and will not be discussed here. On the federal medicare legislation, Mr. Trudeau indicated that he would "stand by the principles embodied in the national medicare plan, and that medicare is now the law of the land and the principle of universality which it embodies can't be negotiated."[52] With Trudeau as leader and with a federal election underway, the national Liberal Party found it necessary to maintain party unity so as not to hurt their electoral prospects.

Through the operation of cabinet solidarity, Prime Minister Trudeau was able to prevent provincial governments, including the Manitoba Government, from capitalizing upon Liberal Party disagreements. The provinces were left with no room to maneuver and could delay no longer. Premier Weir recognized that if he did not participate in the federal plan, Manitobans would probably have supported plans in British Columbia and Saskatchewan. No mention

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[50] Canadian News Facts, 1968, p. 49

[51] Ibid, 1968, p. 57.

[52] "Trudeau against revised medicare," The Winnipeg Tribune, 4 June 1968, p. 2.

was made at this point of former Premier Roblin's ultimatum that Manitoba would insist upon compensation for revenue foregone as a result of its non-participation. Furthermore, Trudeau's Liberal Government was not going to revise the medicare legislation. Therefore, Premier Weir hoped for a Liberal defeat in the June 25th federal election, which might abate mounting pressures upon his government to introduce medicare.

Meanwhile other factors arose which prevented Weir's government from staying out of the federal scheme. On May 6, 1968, Dr. D. M. McPhail, President of the 1,012-member Manitoba Medical Association, announced that the 622,000 subscribers insured by the Manitoba Medical Service, a doctor-operated corporation, would require an average 23 per cent increase after July 1st, to meet a new doctors' fee schedule.[53] The Manitoba Medical Service also announced it would pay only 75 per cent of the doctors' fee, with the balance to be collected directly from patients reporting taxable incomes of over $1000 a year. This move proved unpopular and was attacked by the news media, citizen groups and the Manitoba Federation of Labour. The Weir administration did nothing to counter the Manitoba Medical Association's demands for higher fees,

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[53] "Weir sess small rise in premiums," The Winnipeg Free Press, 7 May 1968, pp. 1-2. See also, Saywell, Canadian Annual Review, 1968, p. 164.

probably because Premier Weir was awaiting the outcome of the June 25th federal election to see if medicare would be introduced by July 1, 1969 and the form it would take. On June 17, 1968, Health Minister Witney announced that the province would re-open negotiations on medicare. Premier Weir confirmed this on June 19th and said on the day after the federal election that Manitoba would enter medicare by the end of the year.[54]

Manitobans started enjoying the federal scheme as of July 1, 1969, when the Medical Services Insurance Act was implemented.[55]

This chapter illustrated that while medicare was officially established, the plan was a long way from being acceptable to the province. The provincial government protested that (a) the plan was an invasion of provincial rights; (b) the province could not afford it and (c) other objectives merited priority in spending. These complaints increased to outright chagrin at the federal-provincial conference in November 1968 when the federal government announced that there would be no changes in the plan. This chapter also illustrated how the provincial government was constrained in its action by the existence of a federal system. The appeal of a federally sponsored

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[54] Saywell, Canadian Annual Review 1968, p. 165.

[55] Shillington, The Road to Medicare in Canada, p. 169. See also, Annual Report of the Manitoba Hospital Services Commission, by J. B. Morison, Chairman (Winnipeg: Queen's Printer, 1971) p. 1.

scheme to the general public and the financial leverage exerted by Ottawa on the provinces, made the provincial government's position a difficult one. While there were external forces on the provincial government, there were as well, internal forces to consider. The role and influence of the various participants in the decision to implement medicare now can be analyzed.

CHAPTER IV

THE ROLE AND RELATIVE INFLUENCE OF VARIOUS PARTICIPANTS IN THE POLICY PROCESS ON MEDICARE

This chapter examines the role and relative influence of various participants in the policy process in Manitoba. At the outset it should be noted that it is difficult to disentagle the contending forces at work because of the complexity of the multiplicity of environmental and institutional forces at work. Part of the problem also is the secrecy which surrounds the crucial decision-making stages within a cabinet - parliamentary system of government like that in Manitoba. It is not possible, therefore, to indicate precisely the relative influence of the various groups, although it may be possible to identify the main actors from the subsidiary ones.

The factors that influenced the final shape and timing of medicare were many and varied. In attempting to review the importance of all the factors involved, there is the danger of lapsing into mere narrative. The most important factors were the financial incentive from the federal government to the provinces and the federal-provincial relations especially at the political level. The provincial premiers saw that medical care was politically popular and impossible to resist. It was also shown in Chapter I that public opinion regarding the appropriate role of government in the provision of health services was changing gradually, creating a favourable climate of public opinion in regard to the introduction of medicare. Furthermore, there had been a declining

respect and trust for the medical profession. A Report of the Special Study of the Medical Profession in Ontario showed that, while doctors were rated highest in importance to society over other professions, there appeared to be an "erosion of respect for and trust in doctors".[1] This lack of trust and respect for doctors by the public probably increased the public's support for the role of government in the provision of health services.

The role of the various participants will be examined under the following headings: (a) The influence of the Manitoba Medical Association, including its structure, its ideological position, and its tactical approach to the issue of medicare; (b) The role of the insurance companies in Manitoba, particularly the Manitoba Medical Service; (c) The role of assorted groups in support of medicare, such as organized labour, welfare organizations, consumer organizations and the citizen's committees; (d) The influence of the political parties; (e) The impact of the province's relation with the federal government; (f) The influence of the relevant department within the provincial government.

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[1] Edward A. Pickering, Report of the Special Study regarding the Medical Profession in Ontario (Toronto: Ontario Medical Association, 1973), pp. 18 - 28.

(a) The influence of the Manitoba Medical Association:

Of all the groups involved in the medicare conflict in Manitoba, the Manitoba Medical Association attracted the most public attention. The reasons were two-fold: Firstly, the Manitoba Medical Association had been involved in debates on health insurance with the provincial government since the 1930's.[2] Secondly, the Manitoba Medical Association placed great importance on its professional autonomy and opposed increased state intervention in the provision of medical services.[3] The Manitoba Medical Association was concerned about its conditions of work based on the institutional arrangements that emerged to finance the cost of medical care. These arrangements were based on two opposing values, namely, those founded on voluntary participation as against those created by compulsory participation. The voluntary arrangement consisted of service contracts signed by the medical profession with MMS. The compulsory arrangement was that administered by the government and organized on a universal, comprehensive basis. In the conflict between the government and the Manitoba Medical Association, on the issue of

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[2] During the depression years the Rowell-Sirois Commission whose report was released in 1937 advised the Federal Government to inaugurate a system of grants in aid to provincial health programmes.

[3] Blishen, Doctors and Doctrines, chaps. 2, 3, 6. See also, Grove, Organized Medicine in Ontario, chap. 4. See also, M. G. Taylor, "The Role of the Medical Profession in the Formulation and Execution of Public Policy". Canadian Journal of Economics and Political Science, 26 (February 1960): 108-127.

medicare, the government refused to accept the profession's definition of their role.

(i) Structure:

The Manitoba Medical Association was founded in 1908.[4] Its existence predated government interest in health care insurance. Indeed, the Manitoba Medical Association and the Canadian Medical Association were on record as early as 1930, urging the government to make health insurance available to the people of Manitoba and Canada.[5] The Manitoba Medical Association, a division of the Canadian Medical Association, is the professional association for physicians in the Province of Manitoba. A voluntary organization, it is considered the 'voice' of organized medicine in the province, and responsible for pressing for the general economic interests of the profession. It publishes and maintains the profession's schedule of fees. By agreement, the association is recognized by the Manitoba Hospital Services Commission as the agent for physicians in relation to payments to physicians for their services under the Manitoba

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[4] Interview with Dr. G. E. Mosher on 31 January 1977.

[5] Ibid.

Health Care Insurance Plan. Total membership in the Manitoba Medical Association in 1969 was 1,037 out of a total of 1,251 doctors in the province.[6]

The government of the association is vested in the Executive Committee. The work of this committee is facilitated by the creation of seven district medical societies in the province. They are situated so that they facilitate communication at the local level. Through these societies, district representatives can obtain the views of members and convey them to the Executive Committee, and report back on the Committee's transactions.

Let us now describe the organization, and success or failure of the Manitoba Medical Association. It should be noted that the role of the Manitoba Medical Association cannot be discussed without reference to its national body, the Canadian Medical Association.[7] Eckstein tells

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[6] Report of the Registrar of the College of Physicians to the Council of the College.(Winnipeg: September 1976), p. 4.

[7] The Canadian Medical Association is composed mainly of provincial associations each of which is autonomous within its particular province. The C.M.A. was formed in 1867. See, Taylor, "The Role of the Medical Profession in the Formulation and Execution of Public Policy", p. 111. See also, Canada, Laws, Statutes, etc., An Act to Incorporate the Canadian Medical Association 1909, ch. 22. In 1967, it had a General Council made up of approximately 180 members, drawn from the different provincial divisions. The national office of the C.M.A. has a full time staff of four officials. Membership in the C.M.A. is gained through membership in the provincial divisions. At the time the federal medicare scheme became law, the C.M.A. had a membership of approximately 17,831 out of a potential number of about 27,544 doctors. See Canada Year Book 1973, An annual review of economic, social, and political developments in Canada (Ottawa: Information Canada, 1973), p. 252.

us that,

> "the reason for the failure or success of a group relate to its own structure and to that of government, to the existing governments policy orientations, and to the extent of conformity of the groups interest to the needs of the environment."[8]

This hypothesis had been confirmed by this case. While the Manitoba Medical Association had the political resources, the leadership of the Association failed to attract favourable public opinion towards Manitoba Medical Association policies. The position of the leadership, supported by a majority within the Association, was that only physicians represented by the Manitoba Medical Association at the provincial level and the Canadian Medical Association at the national level, had the training and experience to construct a satisfactory programme of health care. To the public such an assertion of professional autonomy produced an image of an economically privileged group attempting to preserve their position.

In these circumstances, the profession consistently defended the interest of individual physicians in preserving their ability to exercise entrepreneural discretion.[9] This was the mandate communicated

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[8] H. Eckstein, Pressure Group Politics (London: George Allen and Unwin, 1960), pp. 15-39.

[9] For more information on the profession's entrepreneural discretion and behaviour, see Carolyn J. Tuohy, "Pluralism and corporatism in Ontario Medical Politics", in Business and Government in Canada: Selected Readings, 2nd edition, edited by K. J. Rea and J T. McLeod (Toronto: Methuen, 1976,) pp. 395-411. See also, Blishen, Doctors and Doctrines, especially chaps. 6 and 10.

to the Executive by the MMA membership. In its dealing with government, the executive in turn sought to preserve the individual physician's discretion over the prices charged in particular cases against government attempts to establish a fixed fee schedule as basis for medical remuneration and to negotiate that fee schedule with the profession. The Manitoba Medical Association had consistently opposed the negotiation of fee schedules with the government.

(ii) Ideological approach:

The image of the profession was not helped by the disastrous decision to support the strike of the Saskatchewan Medical Association in July 1962. Several persons died, including a child, because of the withdrawal of physician services.[10] Thus it appeared that the association was a group which had mobilized all its available resources to resist a government proposal, but had failed.

The doctors strike in Saskatchewan in 1962 had revealed the determination of the profession at that time to oppose universal medical care insurance. The association was concerned about the increasing

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[10] For further details, see Ken MacTaggart, The First Decade: The Story of the Birth of Canadian Medicare in Saskatchewan and its development during the following ten years (Toronto: Canadian Medical Association, 1973), chap. 7. There were opposing views on the events from groups like the K.O.D. (Keep our Doctors Committee) who supported the doctors. At Birch Hills District of the province, during a by-election campaign 50 women picketed a private meeting held by the C.C.F. member of the Legislature, Arthur Thibault. Their signs read: We want Freedom for our Doctors' and we Don't want Foreign Scabs. For further details on opposing views, see, Roblin F. Badgely and Samuel Wolfe, Doctors' Strike: Medical Care and Conflict in Saskatchewan (Toronto: MacMillan, 1967,) especially chap. 4.

public support for health insurance and wished to take action to oppose these growing pressures.[11] A strong campaign was mounted prior to and during the Medicare debates in the Commons in 1966, but to no avail. Although there were some suggestions that doctors would withhold their services when medicare was introduced, this did not take place and the profession gradually became resigned to the new system.[12] The Saskatchewan experience was a possible deterrent to such action.

(iii) Tactical approach to medicare:

How does the Manitoba Medical Association achieve its objectives? The interests of the Manitoba Medical Association, like its parent body are achieved in several ways. At its annual meetings, and on all other appropriate occasions, the Manitoba Medical Association issues press releases, statements of policy or principles and briefs to the Legislature and other governmental enquiries.[13] When serious problems arise between the government and the profession, open line-shows, talk shows, speeches, mass meetings of the profession, open to the press with free debate and exchange of policies and views are also used.[14]

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[11] The Financial Post, 10 June 1961, p. 50

[12] For reaction on the Federal Medicare proposals at the April 29th and 30th 1960 Canadian Medical Association Conference, see, "The Federal Government Medicare Proposals", Canadian Medical Association Journal, 94 (May 1966): 1141.

[13] See, for example, Manitoba Medical Association Submission to the Royal Commission on Health Services (Winnipeg: Manitoba Medical Association, 1962).

[14] Interview with Dr. G. E. Mosher on 31 January 1977.

This way the public was aware of on-going discussions between the government and the medical profession whenever the occasion arose.

The second approach is through the formal and informal channels of communication between the government and the profession. The Department of Health and Social Development established a number of medical advisory committees on which Manitoba Medical Association representatives serve. The deputy minister and almost all other senior officials in the Department of Health are required to be medically qualified.[15] Two medically qualified men have been appointed deputy ministers of Health since medical care became law in Manitoba. The post of deputy minister has also been held by laymen.[16] From the point of view of influence, medical representatives are called in

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[15] For details of appointments and qualification of Deputy Ministers and Directors, see Manitoba, Statutes, An Act Respecting the Department of Health, 1961, ch. 20.

[16] Manitoba, Office of the Minister of Health, Annual Reports 1969 - 76. By virtue of the 1961 Act (Ibid), Deputy Ministers and Directors were appointed by the Department of Health and had to be medically qualified. In 1970, the said Act was repealed and replaced by 'The Executive Government Organization Act', see, Manitoba, Revised Statutes, The Executive Organization Act 1970, ch. E170 for details. Under this Act, the Minister of Health, may by written authorization approved by the Lieutenant Governor-in-Council, delegate that power or authority to any person employed under him in the Executive Government, subject to such limitations, restrictions, conditions, and requirements as the Minister may impose and as are set out in the written authorization.

when legislation is being considered. Prior consultation appears to be standard practice between the medical association and the government. When Manitoba Medical Association spokesmen and government officials speak of their mutual relations as being 'good' or 'bad', it is on the issue of consultation that they are most likely to base their conclusions. The association considers relations to be good if it is always given the opportunity to discuss legislation before it is introduced.[17] On the other hand, officials judge relations by the extent to which the association, having been consulted, is willing to 'go along' with the governments' proposals.[18] Although public health officials, by virtue of their training, responsibilities and personal predilections, may view the requirements of public policy in a different perspective, there exists nevertheless, a bond of understanding arising from common membership in a professional elite. This connection with the external interest group, impossible for a non-medical official, may have compensating effects. In addition to the obvious one of providing easier communication, it makes possible, when desirable, a stiffer resistance to arguments that would be presented.

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[17] Interview with Dr. G. E. Mosher on 31 January 1977.

[18] Interviews with Director of Insurance; Secretary to the Manitoba Hospital Services Commission; Manager, Claims Section, and Manager, Information Services - all employees of the Manitoba Hospital Services Commission on 2 March, 1977. They have preferred to remain anonymous.

Another source of influence of the profession is what is termed 'institutional patterns'. The phrase refers to the medical prepayment plans which were sponsored by the medical profession and controlled by it.[19] The Manitoba plan, through the publicity given to its annual meetings, reinforced the policies of the Manitoba Medical Association. The simple fact of its existence was probably the most effective form of influence, actual and potential, on government policy. While the plan's existence strengthened the case for a voluntary approach to medicare, it could be argued with equal plausibility that the plan also demonstrated the value of a pre-paid insurance scheme and thereby contributed to its own disappearance because of the gaps in the coverage. As indicated in Chapter III, the Hall Commission on Health Services came up with similar findings. The public was also coming to understand that there was an alternative to government-run health insurance. The plan had a part to play in the increasing recognition of the public of the value of a voluntary approach to meet the costs of personal health services. This plan ended in 1969 when medicare became a reality.[20] Even after that date, the medical profession continued to play an important role in the administration of medicare through their participation on the Manitoba Health Services

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[19] Interview with Dr. G. E. Mosher on 31 January 1977.

[20] Interview with Dr. Angus Reid, Professor of Social and Preventive Medicine, Faculty of Medicine, University of Manitoba, on 8 March 1977.

Commission Board. The Manitoba Medical Association has almost consistently had at least two physicians on its board (Manitoba Hospital Services Commission) and at least two physicians on each of its committees.[21]

Another source of the profession's influence which is not easily assessed or identified, is the 'tie-in' with other groups committed to similar policies such as hospital associations, and the insurance industry, seeking to protect similar interests and policies. The insurance industry though competing with the pre-payment plans sponsored by the doctors, shared the medical profession's general objective with respect to government action. The insurance industry and medical profession wanted a voluntary scheme with government paying coverage for the poor. On November 22, 1967, A. R. McPherson, President of the Winnipeg Chamber of Commerce from May 1967 to May 1968[22] (and now Chairman of the Victoria General Hospital) sent a telegram to Prime Minister Pearson requesting the postponement of medicare. The influence of other health professions and the hospital boards is usually directed to protect their interests and policies. For example, the Dean of Medicine of the University

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[21] Interview with Mrs. E. Shapiro, Professor of Social and Preventive Medicine, Faculty of Medicine, University of Manitoba, on 8 March 1977. Mrs. Shapiro is also a member of the Manitoba Health Services Commission.

[22] Telephone interview with Secretary, Winnipeg Chamber of Commerce on 20 October 1977. The author also interviewed Mrs. McPherson by phone on 20 October 1977.

of Manitoba is also on the Board of the Health Sciences Centre.[23] Further, the Vice-President and Medical Advisor of the Great West Life Assurance Company is a practising physician, a specialist in Cardiology.[24] This is based on the assumption that a medical practitioner on the board of an insurance company or hospital board will undoubtedly be sympathetic to their cause.

While at the time of medicare there seems to have been unity of purpose between the professionals in the hospital sector and the medical professions, such unity cannot be assumed as was revealed later when health services faced a more stringent budgetary situation. To many doctors their relationship with the hospital "implied a form of remuneration which limited their entrepreneural discretion".[25] As early as 1973, the Pickering Study regarding the Medical Profession in Ontario indicated that,

> "Indeed there is some likelihood that the 'physician care system' and the 'hospital care system' may become rivals for the health dollar. Since both groups are organized interest groups with a sense of separate identity, as well as providers of health care in a sometimes complementary, sometimes substitutable way, this may be a very real risk".[26]

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[23] Interview with Secretary to the Director, Health Sciences Centre, Winnipeg, Manitoba on 8 March, 1977.

[24] Telephone Interview with Secretary to Dr. R. Beamish on 16 March 1977.

[25] Tuohy, "Pluralism and Corporatism in Ontario Medical Politics", p. 405.

[26] Pickering, Report of the Special Study regarding the Medical Profession in Ontario, p. 23.

The Pickering findings coincided with a Canadian Medical Association Submission to the Parliamentary hearing on income restraint when they blamed rising costs on hospitals. They told the Parliamentary Committee that,

> "The problem is, you're putting the restriction on the wrong programme, the increase in medical care costs has been very responsible. But the costs of hospitalization have been going up 18 per cent a year."[27]

It is therefore no exaggeration to conclude that there would be potential for division between the hospitals and doctors when dollar issues emerged.

The success of these influences depends on the degree of cohesion of the association. Traditionally, the medical profession had exhibited remarkable unity. In an interview, Dr. G. E. Mosher, President of the Manitoba Medical Association from 1967 to 1968, described the association as a dynamic democratic organization with a wide spectrum of opinion on many issues.[28] He indicated that, "the degree of unity tends to reflect the seriousness of attack from outside."[29] On the medicare issue, some doctors wanted most patients (except the indigent ones) to pay a small portion of the costs of their care at the time of service, in order to prevent excessive costs. The other area of concern

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[27] Canadian Medical Association, Canadian Medical Association delegation at Parliamentary hearing offers view on income restraint, Canadian Medical Association, 1975, p. 1012B.

[28] Written statement by Dr. G. E. Mosher during an interview on 31 January 1977.

[29] Ibid.

was the way in which medicare rather than a vehicle for payment alone, could become an instrument for political interference in the decisions of doctors and those who run hospitals which affect the health care of the people.[30] While this was an area of major concern, it was not a matter of public disagreement within the Manitoba Medical Association.

Financial resources can also be a determinant of the success of an organized pressure group. Among pressure groups, the medical profession has generally been seen as one of the more affluent organizations. The Manitoba Medical Association is self-financing, through dues from its registered members. These dues are determined from time to time by the association's Executive Committee[31] and

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[30] Interview with Dr. G. E. Mosher on 31 January 1977. For more on professional autonomy, see Blishen, Doctors and Doctrines, chap. 10.

[31] The government of the Association is vested in the Executive Committee. It is comprised of the six officers (President, President-Elect, Vice-President, Immediate Past President, Honorary Secretary and Honorary Treasurer); one representative from each of the Seven District Medical Societies, the Chairman of the Section of General Practice, the Chairman of the Liaison Committee of Speciality Section, and a Representative of the University Faculty of Medicine. This committee meets when necessary, but at least once every three months. The officers of the Association oversee the day to day activities of the Manitoba Medical Association. They are selected by the membership at the Annual Meeting and the remaining Executive Committee members are appointed by their individual Districts or Societies.

are consistent with those charged by other provincial associations. Although some monies were required for the services of a public relations counsel to advise the association on techniques of communication with the population at large, the association denied any outside funding to publicize their case during negotiations with the government.[32] However, there were rumours that it received financial assistance from the American Medical Association. According to provincial officers, the Canadian Medical Association provides little if any financial benefit to its provincial divisions, whose members are thus largely tied to the national organization only by shared attitudes on policy questions.

Let us now analyze the interaction between the Canadian Medical Association and the Canadian governments. Most of the available literature deals with the CMA as a pressure group at the national level.[33] Less is known about activities of the provincial associations. Students of pressure group activity have suggested a number of general themes. First, the structure and operation of cabinet-parliamentary government under modern conditions is characterized by executive

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[32] Interview with Dr. G. E. Mosher on 31 January 1977.

[33] For an understanding of these themes, see, Richard A. Weir, "Federalism, Interest Groups, and Parliamentary Government: The Canadian Medical Association", Journal of Commonwealth Political Studies, 2 March 1973: 159-172. See also Blishen, Doctors and Doctrines, Chapter 9, especially pp. 143-149.

predominance. As a result, according to Richard Weir, "the virtual exclusion of parliament, MP's, and party as a channel for group influence leads the Canadian Medical Association to turn to the executive, ministry and the Prime Minister as the major point of access to the decision-making structure".[34] Executive control over policy development is even more pronounced at the provincial level. Recognition of this fact led the Manitoba Medical Association to deal most frequently with the Minister of Health whenever it approached the government. On important matters, the association might also approach the Premier directly to discuss policy and legislation.

The Manitoba Medical Association, like its parent body, was concerned about the control of their working conditions, freedom of choice, and quality of medical care. Dr. Duncan Kippen, the Association's Vice-President voiced these concerns on April 6, 1967, when he said, "medicare would undermine the basis of free enterprise."[35] With the emergence of a physician sponsored prepayment plan in 1942, the association stressed that public responsibility should be limited to those families and individuals unable to pay the cost of premiums required for such a plan. The outcome of the Saskatchewan medical care

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[34] Ibid, p. 168.

[35] Saywell, Canadian Annual Review 1967, p. 150.

dispute in 1962 and the recommendation of the Royal Commission on Health Services which was not sympathetic to the association's cause, resulted in further opposition to the introduction of a universal scheme. After the release of the report, the association downplayed its opposition to the principle of medicare and laid more emphasis on freedom of practice and autonomy above everything else.[36]

Discussions on implementation of medicare in Manitoba started in 1967 during the Conservative administration of the Honourable Duff Roblin. On November 27, 1967, Mr. Walter Weir succeeded Mr. Roblin as the leader of the Conservative party and as Premier. Mr. Weir served until July 15, 1969 when the New Democratic Party replaced the Conservatives in office. Medicare officially became law on July 1, 1969, during the Conservative administration of Premier Walter Weir. It is interesting to analyse the medical profession's perceptions of their relations with the different provincial administrations over this period of entry into the national plan.

Dr. G. E. Mosher, who was President of the Association at that time, praised the Roblin government for making a legitimate attempt to involve the medical profession in the policy process. In Dr.

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[36] The themes propounded by the Medical Profession are fully discussed in Blishen, Doctors and Doctrines, chap. 10.

Mosher's words, Roblin was a "corporate man who was willing to listen to the doctors."[37] On the other hand, the former President of the Manitoba Medical Association described the Weir government as 'Machiavellian'. He put it succinctly, "Weir was a grass root politician who had no plan. His medicare policy was the result of discussions he held with doctors (some of them were in solo practice or retired) in isolated communities, over a glass of beer."[38] Dr. Mosher also pointed out that,

> "Often times, Weir told the Manitoba Medical Association after such discussions, 'I know what you guys want; I'll give it to you.' The crunch of the matter is that the doctors with whom Weir had discussions were not representative of the Manitoba Medical Association membership. The ideas of the doctors he spoke to and the ideas of the other members of the Manitoba Medical Association were always irreconcilable."[39]

Whether Dr. Mosher's assertion implied unity or not within the association, was hard to prove or disprove. One cannot avoid the impression that there were disagreements over policy issues especially when one takes into consideration the fact that the number of professionals other than doctors who wanted to have a say in the operation of the system has also multiplied. At the same time, the fact that Premier Weir's

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[37] Interview with Dr. G. E. Mosher on 31 January 1977.

[38] Ibid.

[39] Ibid.

pronouncements were the result of discussion with retired doctors and those in solo practice, led one to conclude that these doctors did not share the views of the association, even if they were members in good standing. Dr. Mosher's characterisation of Premier Weir as a grass root politician was apparently based on the perception that Premier Weir was primarily concerned with positive and negative votes as well as the political climate of the time. As such, even if he failed to consult his Minister of Health, Charles Witney, he did so without prejudice. However, there was no public disagreement between Premier Weir and his Minister of Health on the medicare issue.

With respect to the N.D.P. Government Dr. Mosher charged that,

> "the government had consistently attempted to avoid communication with the medical profession, except with the 'trained seals' that it hires as medical yes-men. However, the government and the Department of Health made all reasonable efforts to involve the Manitoba Medical Association and the physicians in the development of the operative legislation during Manitoba's entry phase into the federal scheme. But since then the N.D.P. government has repeatedly ignored the legitimate input of the doctors' organizations, choosing to impose its own dogmas and to refer questions of policy affecting physicians to non-doctors or to medical yes-men."[40]

The conservative orientation[41] of the profession affected its members' image of the N.D.P. administration and their interpretation of its

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[40] Ibid.

[41] For further details on this aspect of the profession see, Blishen, Doctors and Doctrines, especially ch. 3. See also, Committee on the Healing Arts, Report (Toronto: Queen's Printer, 1970) especially chaps. 24, 25, 26, 30.

policies. To the average physician trained in the conservative mould of Canadian medical schools, associating with highly independent and professionally autonomous colleagues in internship, residency, and subsequent practice, and exposed to the conservative perspective of the provincial association, the N.D.P. administration was seen as a radical party which offered proposals that appeared to aim at the destruction of professional autonomy.

Why was the N.D.P. perceived as a radical party? The N.D.P. succeeded the C.C.F. (Co-operative Commonwealth Federation) in 1961. The history of the C.C.F. and the N.D.P. has been fully documented elsewhere.[42] The ideological stand of the C.C.F. was democratic socialism. The goals of the C.C.F. and the belief in the cause of socialism continued to form the core of the N.D.P.. The New Democratic Party leader in Manitoba indicated that, "the philosophy of the N.D.P. stressed an activist approach to government, in which the 'instrumentality of government in the public interest' is used to create a more equitable distribution of the goods of the world and a greater equality in the human condition."[43] He felt strongly that a social democratic government based on this philosophy could, in very practical ways, realize progressive

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[42] N. H. Chi and G. C. Perlin, "The New Democratic Party: A Party in Transition", in Party Politics in Canada (Scarborough, Ont.: Prentice-Hall, 1972), pp. 177-187. See also, Walter D. Young, The Anatomy of a Party: The National C.C.F. (Toronto: University of Toronto Press, 1969).

[43] Paul Beaulieu, ed., Ed Schreyer, a Social Democrat in Power (Winnipeg: Queenston House, 1977), p. 1.

reforms to bring about greater economic equality and social justice.

Rising costs and new demands upon the health system would have meant that friction over policy matters would arise regardless of the party in power, but the mutual suspicion that characterized the Manitoba Medical Association - N.D.P. relationship undoubtedly compounded the problem of communication and compromise.

It is difficult to determine whether Dr. Mosher's views were representative of the views of the general membership of the Manitoba Medical Association. Certainly, he was the association's most prominent spokesman during the medicare discussions. Moreover, the secrecy in which decisions were reached, and the latitude allowed the executive committee within the Manitoba Medical Association's structure suggest that he was speaking for the bulk of the Manitoba Medical Association.

It is interesting to speculate why organized medicine, previously so successful in achieving its objectives, was defeated on the medicare issue. As indicated in Chapter III, it could be speculated that the Manitoba Medical Association's support for Bill 68 was based on the realization that the battle over the principle of implementing medicare had been lost. The Bill had already passed second reading. At this juncture, the best the Manitoba Medical Association could hope for would have been the introduction of the scheme on better terms.

Further, the enabling provincial legislation reflected the increasing extent to which health care had been viewed as a public issue and responsibility rather than the preserve of a professional group. Medicare was a reflection of this change. On the whole, it could be concluded that the medical profession gained better terms on the medicare issue. Maurice LeClair in his analysis of the Canadian Health Care System indicated that,

> "the things that the medical profession really wanted were incorporated in the plan; there was opting out; this opting out was without penalty to the physician or patient; the patient-physician relationship was protected; there was continuation of the selection of a physician by a patient rather than by a panel system; a physician could choose his patients and there was really no interference by a third party in the direct delivery of this service even though the third party did provide the payment." [44]

While these concessions reflected the Canadian Medical Association's efforts at the national level, they were embodied in the provincial legislation which brought medicare to Manitoba.[45] It was not clear how important these concessions were to the CMA. However, the 'opting out' arrangement was listed as being of extreme importance to the profession at both the provincial and the national levels.[46]

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[44] Maurice LeClair, "The Canadian Health Care System", in National Health Insurance: Can we Learn from Canada? ed. S. Andreopoulos (N.Y.: John Wiley, 1975), p. 22

[45] Manitoba Statutes, The Health Services Insurance Act, 1970, ch. H35, especially sections 38(4), 38 (5), 39(1), 39 (2), 40(1).

[46] "Conference on Medical Care Insurance," Canadian Medical Association Journal, 100 (January 1969): 130A.

(b) The role of the insurance companies:

One of the groups that joined the Manitoba Medical Association in opposing the medicare scheme was the insurance companies, particularly the Manitoba Medical Service, whose executive saw the requirement that the plan be administered on a non-profit basis by a public authority as particularly damaging to its interests. This meant that the insurance companies would run into financial difficulties when faced with escalating costs and being constrained from raising premiums and realizing profits. However, once medicare became a reality many of the health insurers began to examine ways of 'co-existing' with the new insurance system. Many moved into the area of ancillary coverage for aspects of treatment not covered by the provincial medical care plan. In Saskatchewan, for example, the early experience of some health insurers was that the removal of ordinary doctor services from their organization was an advantage as this had been the least profitable end of their operations.[47] Other groups opposed to medicare were business organizations such as the Winnipeg Chamber of Commerce, who apart from their generally conservative political ideology, in many cases had close relationships with the medical profession.[48]

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[47] The Financial Post, 19 January 1966, pp. 1-5.

[48] Citizen Committee on Medical Costs Minutes, "Manitoba Medicare: Decision to Enter" (undated), p. 37. See also, Saywell, Canadian Annual Review 1967, p. 150.

(c) The role of miscellaneous groups:

Lining up in favour of the Medical Care Act were organized labour, medical consumer groups, welfare organizations and many sections of the mass media. These groups began pressuring the Weir government after he announced on February 2, 1968, that Manitoba would delay the implementation of the Federal Medicare plan,[49] in the hope that changes and amendments would be made to the formula by Ottawa. The pressure intensified once opinion leaders of various groups discovered the proposed higher costs of medical insurance after July 1, 1968. The Winnipeg and District Labour Council voiced its dissent by sending telegrams to Premier Weir condemning the provincial government's 'lethargy'. In one of its telegrams, the council said, "Mr. Premier, you represent the state - let's get on with medicare".[50] On May 17, the President of the Manitoba Federation of Labour,[51] R. J. (Bud) Henderson, issued a public appeal for a mass demonstration in favour of immediate introduction of national medicare for Manitoba. He also told Premier Weir and the MLA's from both sides of the House that if medicare were rejected, the Manitoba Federation of Labour would, for the first time, become active politically in the next election. Mr. Henderson was backed

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[49] "Medicare marchers warn Weir", The Winnipeg Tribune, 17 May, 1968, p. 25, See also, Canadian News Facts, 1968, p. 18.

[50] Telegram sent to Premier Weir by A. Coulter, Secretary of the Winnipeg and District Labour Council, February 23, 1968.

[51] This group is not listed as one of those that appeared before the Hall Commission, although their Winnipeg Office confirmed on 7/11/77 that they made a submission through their national body-the Canadian Labour Congress.

up by approximately one hundred protest marchers made up of trade unionists and social workers. At the same time, Art Coulter, the Manitoba Federation of Labour executive-secretary and for six years a non-medical member of the Manitoba Medical Service, presented Premier Weir with an 8000-name petition[52] urging adoption of medicare.

At the end of April 1968, a group of interested citizens met, at the invitation of Harold Chorney, provisional secretary for the group, to discuss the possibility of establishing a non-partisan committee to look into all facets of medical health insurance in Manitoba.[53] The Citizen's Committee on Medical Costs, as this group came to be known, was to examine the role of the doctors, the Manitoba Medical Service, the government, and the public in determining costs and conditions of medical coverage in Manitoba.[54] The Citizen's Committee subsisted on two dollar donations. In order to publicize the problem of rising medical costs to the citizens of Manitoba, the Citizen's Committee utilized hot-

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[52] The Winnipeg Tribune, 17 May 1968, p. 25.

[53] Interview with Mr. Thomas Peterson, University of Manitoba, Winnipeg, on 25/5/76. Mr. Chorney was a student at the University of Manitoba. Mr. Peterson was also invited to the meeting held at the Charter House Hotel in downtown Winnipeg. He later became Chairman of the Citizen's Committee on Medical Costs.

[54] "Group to Probe Insurance Set Up", The Winnipeg Tribune, 21 May 1968, p. 23.

line radio programmes, T.V., newspapers, and held press conferences.[55]

Before the announcement that the province would proceed with medicare, a city wide 'blitz' for the collection of signatures on a petition was arranged. By the time the 'blitz' was completed, the government announced that it would enter the federal scheme.

On May 31, 1968, the Committee's Chairman, Mr. Tom Peterson, told a public meeting on medical costs at Sargent Park School that the Committee hoped to collect 100,000 signatures by June 8, 1968, from Winnipeggers who were in favour of a plan involving federal participation and financial premium support for those unable to pay all or part of the premium.[56] The petition did not explicitly endorse medicare.

The Citizens' Committee collected approximately 50,000 signatures. This was a significant number, but the petition was never presented to the Premier because of the announcement of the provincial government's intention to enter the federal plan. Failure to present the petition was not crucial as the government was the object of growing pressure to take a decision on medicare.[57]

At a meeting called by the Citizens' Committee on Medical Costs, Health Minister C. H. Witney, Liberal M.L.A. Larry Desjardins, New

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55 Interview with Mr. Thomas Peterson on 25/5/76.

56 The Winnipeg Tribune, 1 June 1968.

57 Ibid.

Democratic Party M.L.A. Sid Green as well as Dr. Derek Gellman, Economics Expert of the Manitoba Medical Association and independent economist Hubert Prefontaine spoke to the audience. Mr. Witney denied charges that the provincial government is "dragging its feet in getting medicare for Manitobans and said the Weir Administration merely wants to proceed cautiously to make sure the system finally implemented here stands the test of time."[58] Mr. Desjardins told the meeting he agreed with the Manitoba Medical Association to introduce a new fee schedule because it eliminated imbalance in service remuneration to doctors.[59]

The Liberal M.L.A. faulted the Conservative government for not having thorough negotiations with the Manitoba Medical Association. Mr. Green, the New Democratic Party M.L.A., agreed that fee increases for doctors were necessary, but also endorsed the national medicare plan for Manitoba.[60] Dr. Gellman of the Manitoba Medical Association whose address was greeted by loud booing, attacked Mr. Green for his

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[58] Ibid.

[59] Ibid.

[60] Ibid.

speech on the advantages of the federal scheme, as "nothing but loud noises from the lung appearing to be important messages from the brain."[61] He also charged that the medical profession was being ridiculed by the mass media. Singling out the Winnipeg Tribune and a number of open-line radio programmes, Dr. Gellman said,

> "they haven't got the facts and make no attempt to get them. All they do is to quote rumours and informed sources. They are pilloring an honourable and learned profession in an attempt to destroy the confidence of the public in their doctors and in the Manitoba Medical Service."[62]

After that meeting, the Committee on Medical Costs suggested that it would stage a march for more names if 50,000 were not enough. The meeting was intended to air the issues surrounding announcements on the changes in Manitoba Medical Service coverage of approximately 622,000[63] subscribers and the premium increases combined with possible extra-billing charges by doctors in the province.

During the first week of June, although one candidate refused to answer, the Citizens' Committee obtained support of Federal candidates of the three major parties in the six ridings of

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[61] Ibid.

[62] Ibid.

[63] Shillington, The Road to Medicare in Canada, pp. 127 - 204, See also, Saywell, Canadian Annual Review 1968, p. 164.

metropolitan Winnipeg on medicare under the federal government's terms, and according to Committee Chairman Thomas Peterson, "this confirmed our impression that with sufficient effort Manitobans could get a better deal with respect to the problem of rising medical costs."[64]

There were negative reactions about the role of the Citizens' Committee on Medical Costs from various quarters. "A few people, including the medical profession, thought the Committee on Medical Costs was against doctors".[65] However, Dr. Mosher felt that the Committee was an association of individuals freely dissenting from the policy of government of the time which was to delay the implementation of the Federal Statute in Manitoba for at least a year. The main target, according to the past president of the Manitoba Medical Association appeared to be the government of the time. The Committee he claimed, "appeared to have been captured by the N.D.P. opposition".[66]

On the other hand, Mr. Peterson, Chairman of the Citizens' Committee on Medical Costs, tells us that the N.D.P. refused

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[64] Interview with Mr. Thomas Peterson on 25/5/76.

[65] Ibid.

[66] Written statement by Dr. G. E. Mosher during interview on 31/1/77.

even to endorse the Committee, and that the Committee drew support from persons of all parties. This contention is supported by the fact that in response to a questionnaire circulated by the Committee to all candidates in Winnipeg ridings in the 1968 federal election campaign only one, Mr. Vaughan Baird, the Progressive Conservative candidate in St. Boniface, failed to support the goals of the Committee. Even Mr. Baird expressed general agreement, but claimed he could not endorse the Committee outright because he was a member of the Manitoba Hospital Services Commission, and hence, in possible conflict of interest.[67]

In explaining the purpose of the Committee, Mr. Peterson said,

> "The Committee on Medical Costs no doubt was supported by very few people who were generally against doctors, and perhaps because they had not received satisfactory medical treatment. The Committee did not welcome this kind of support. But any such petition is signed by persons with a variety of motives. A few doctors did support the Committee, but many did not, again no doubt for a variety of reasons. Personally I always hoped for more support from the medical profession - because I felt the Committee's goal was compatible with the doctors' best interests".[68]

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[67] Interview with Mr. Thomas Peterson on 26/3/77.

[68] Ibid.

It was also alleged that the group was against doctors' incomes. In reply to this, Mr. Peterson said,

> "It is my impression that the great majority of doctors work much, much harder than most persons in society. Also their work is clearly of crucial importance to their patients and of fundamental importance to society in general. Medical care is more important than education for example because if individuals aren't well they obviously cannot be expected to be effective students. And medical care is clearly much more important than many other activities in society such as advertising, selling automobiles, liquor, etc. Accordingly, in a society of differential incomes, my own judgement is that the income for medical service should be well above average. But I want to emphasize that this is merely my view - the Committee's intent was <u>never</u>* to attack the income of the medical profession. Its concern was rather with the <u>distribution</u>* of medical costs and the availability of insurance (whether private or public) to secure individuals from the financial catastrophe threatened by prolonged illness."[69]

The Committee on Medical Costs was only concerned that a better arrangement be made for Manitobans. If Manitoba did not enter the federal scheme, Manitobans would be supporting schemes in other provinces through taxes and receive no benefit. Manitoba Medical Service coverage was no longer complete as only three quarters of the cost was covered. The Committee was also concerned about the fact that the Manitoba Medical Service was no longer comprehensive and its future appeared in jeopardy, and one third of Manitobans had no insurance coverage at all. Medical fees were also being increased.

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69 Ibid.

*Emphasis by Mr. Peterson

The Citizens' Committee was in no way advocating medicare. It wanted the Manitoba government only to reconsider its position and take action to meet these problems. It did not seek to prescribe any definite action to the government; what it wanted, according to Peterson, was to express concern over the government's apparent inaction. While the group did not explicitly favour medicare, there is no doubt that some of its members, especially among the aged, were in favour of the scheme. There were others who favoured a supplemental role for government.[70] According to Mr. Peterson, a straight declaration in favour of medicare was avoided because the Committee's members were not experts on the various types of medicare and it was a government* responsibility to find and apply the necessary expertise to the problem of securing a better* arrangement for Manitobans, rather than merely postponing consideration of the issue for a year. Despite these differences of opinion, there was a general consensus that medicare was the only solution for the high cost of services at a time when approximately one third of the population had no form of medical coverage.[71]

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[70] Telephone interview with Harold Chorney on 8/11/77.

*Emphasis by Mr. Peterson

[71] Interview with Mr. Thomas Peterson on 26/3/77.

It is human nature to ask at the end of any altercation, 'who won?' It seemed clear that nobody won the fight over the medicare legislation. The medical profession did not win; they were unable to halt the public pre-paid medicare programme, although they obtained protection of their professional status by the opting-out arrangement. The Government did change its policy. This was substantially what the Citizens' Committee was seeking. However, it would be wrong to suggest that the Citizens' Committee forced the government to change its policy. The plan was more confusing and almost certainly would be more costly. The government did not win - it still had to rely on an embittered profession to co-operate in making the plan work. But no sane person would suggest that the fight should be renewed in order that a winner could be declared. Problems undoubtedly developed, as in any new plan, but The Act was sufficiently flexible that most of them could be ironed out. The fact that the major political parties in the Legislature and the medical association participated in the meeting was an achievement in the right direction. While their opinions differed, the meeting demonstrated that in a spirit of co-operation and increasing mutual respect, all could work together well in basic common recognition that the basic purposes and goals were not really in conflict.

The success of the Citizens' Committee is difficult to measure. Eventually, the government revised its decision at the end of June 1968 and announced that it would negotiate entry into medicare. This met two problems which concerned the Committee, namely, (a) Manitoba would receive its share of federal contribution; (b) medical care insurance would continue to be available, as it had been under the Manitoba Medical Service.

There was jubilant celebration by the Committee in response to what it considered a success. Mr. Peterson is realistic, however, in recognizing that it would be too much to claim that the Committee caused the government to change its policy; at the most, the Committee's expression of concern was only one of several influences in a complex equation. In his view, the government might well have changed its policy on its own, even if the Committee had not existed.[72]

The Citizens' Committee on Medical Costs was a Winnipeg based group with no committees formed elsewhere in the province. However, the Committee received letters of support and completed petitions from all over the province. While the Committee made attempts to publicize its aims to Manitobans by radio, T. V., etc. the parliamentary system of government made it difficult for the Committee as a successful lobbyist.

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[72] Interview with Mr. Thomas Peterson on 28/3/77.

Whether or not his pronouncements were his or those of his Committee, I think it permissable to say that Mr. Peterson showed effective leadership in championing the cause of his Committee to publicize the advantages of a prepaid programme for Manitoba.

Acting independently was another group based in Brandon known as the Citizens' Committee for Medicare formed on March 17, 1968.[73] Its President was Dr. M. V. Naidu, Professor of Political Science at the University of Brandon. The groups' existence and its objectives were apparently not well known in Brandon, although it tried to enlist the support of the Brandon City Council. Only one city councillor and one alderman attended one of its meetings. The group's limited publicity to residents of Brandon and surrounding districts was done through newspaper ads, radio and T.V.[74] The sole concern of the group according to its President was the fact that many doctors resident in Brandon decided to 'opt out' of medicare.[75] The group feared that Brandonites would receive poor services if any at all. There was also the concern that Brandonites would be extra-billed coupled with the administrative responsibility to get reimbursement from the Health Services Commission.

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[73] *The Brandon Sun,* 20 March 1968.

[74] *The Brandon Sun,* 31 March 1968.

[75] *The Brandon Sun,* 20 March 1968.

In its attempt to remedy the situation, the group launched a signature campaign on April 15, 1968 to enlist the opinion of Brandonites sympathetic to their cause in order to forward a petition to Premier Weir. They collected 2,300 names[76] and a petition was delivered to the Premier on May 20, 1968 by a delegation of the Committee. Copies of the petition were sent to MLA's of the three major parties in Manitoba. The response from Premier Weir was a 'promissory note' to do something about the petition.

Because the group limited its concern only to the 'opting out' arrangements without mention of other aspects of the prepaid programme like maldistribution of services, etc., it failed to attract many people. This, possibly, led to its early disappearance. While the group's impact was not direct, it presumably contributed to the overall impression of public concern. It subsisted on contributions from its members.

Perhaps the Brandon and Winnipeg groups should have amalgamated their efforts. This would have provided a broader base with greater coordination. The combined efforts would have led to more publicity of the group's objectives. This, in turn, would have led to more participation of Brandon area residents.

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[76] The Brandon Sun, 20 May 1968.

Another group of less significance were the consumers. Consumers of medical services have never been well organized in Canada, and there is little evidence of such groups playing a significant role in influencing the Medicare Act. Of the thirty submissions received by the Hall Commission from Manitoba, approximately, twenty-three per cent were from groups representing those members of the community who have chronic illnesses and who thus are highly dependent on health services (eg. The Society for Crippled Children and Adults of Manitoba, The Association for Retarded Children in Manitoba, etc.).[77]

(d) The influences of the political parties:

Let us now turn to the role of the political parties. Manitoba's political parties played an important part in the development of medicare. All three parties were electorally committed to medicare in the 1966 Manitoba election. The Conservatives supported a voluntary arrangement, the New Democratic Party supported a universal compulsory scheme and the Liberals wanted a voluntary scheme, but would support a compulsory scheme if one was necessary.[78] There was no change in the 1966 commitment to medicare by the three political parties when the Bill was introduced in the legislature in

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[77] For a complete list of groups who made submissions see, Hall Commission, pp. 889-903.

[78] Saywell, Canadian Annual Review 1966, pp. 132-133.

March 1967.[79] The financial incentive from the Federal Government and the political popularity made medicare attractive to Manitoba, no matter what party was in office.

(e) The Federal-Provincial Relations:

Another element of the development of medicare in Manitoba was her relations with the federal government. The years before 1969 witnessed recurring disputes among attentive segments of the public in Manitoba over the issue of medicare. The federal government also got into the act by prescribing four principles which had to be adopted to qualify for federal subsidy.[80] Relations between Manitoba and the federal government were strained as a result. As shown at the beginning of this chapter, medicare was politically popular and the provinces knew they did not have the money. Ultimately, there was no way the province could resist the political pressure to adopt the national plan.

(f) The influence of the provincial government:

The influence of the provincial government itself in the development of medicare should now be considered. Events in other parts of Canada had decisive influence on policy-making in Manitoba in the medicare case.

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[79] For further details, see, Manitoba Debates, Vol. XIII (1967), pp. 1576-1580. See also Chapter III of this Thesis, especially pages 54-55 where voting on the Bill is indicated.

[80] The four principles are explained in Chapter III of this Thesis, especially pages 43 - 45.

Manitoba and the other provinces opposed medicare at conferences held in January 1966, October 1967, and October 1968.[81] However, the fact that the federal government was able to over-ride the very strong opposition of the most powerful provinces of Ontario and Quebec in introducing its scheme, indicated their weakness at that time relative to a federal government, with control over financial resources, strongly intent on having its way. Further, the example set by Saskatchewan in establishing its own comprehensive medical care plan in 1962, provided a model which was later introduced by Manitoba and other Canadian governments. Manitoba and the other governments had no mechanism with which they could have prevented the proposal from becoming a reality. It was only a question of timing to enter the federal scheme.

Manitoba recognized that British Columbia had established a government-sponsored plan instead of utilizing the services of voluntary agencies and private insurance companies. Further, the eventual determination of the federal government to adhere to its announced pattern for a federal medicare programme, left Premier Weir and his team no alternative but to adopt the federal plan. The uncertainty caused by the impending resignation of Prime Minister Pearson has been documented in Chapter III.

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[81] Joe Martin, The Role and Place of Ontario in the Canadian Confederation: The Evolution of Policy in Contemporary Ontario. No. 4 (Toronto: Ontario Economic Council, 1974), pp. 25-26.

A change of Premiers in the fall of 1967 in Manitoba, and national events provided an opportunity for the province to equivocate further on the medicare issue. However, mounting demands from the public for the Manitoba government to join the federal plan still continued. By mid-summer, Premier Weir countered by saying that,

> "There has been no question that Manitoba would enter the federal medicare plan. The delay in formulating our plan has been the result only of trying to devise the best plan to suit our needs and at the same time be acceptable to the federal government."[82]

Despite the conflict of interest among the various participants, medicare in Manitoba became a reality in July 1969. There was no record of any disagreement within the Manitoba Cabinet or between the government departments which were involved in the medicare issue.

In this chapter an attempt has been made to indicate the role of the various participants in the policy formulation as it affected medicare in Manitoba. The chapter also illustrates that there was almost complete agreement that medical insurance should be available to all regardless of age, state of health or financial status. There was also near unanimity among spokesmen for the various groups, eg. consumer groups, the insurance industry, and the health professions that some form of government action was necessary to bring about the desired objective. At the same time there was strong disagreement as to the method and scope of government action required.

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82 Shillington, The Road to Medicare in Canada, p. 169.

However, agreement between the government and the profession resulted in an arrangement where direct payment to physicians for their services were paid for by the Health Services Commission established by the government.

The insurance industry was also examined in this chapter. The insurance industry originally opposed to a comprehensive medicare programme, sought ways to co-exist with the provincial medical programme by moving into areas which were not covered by the medicare scheme.

The chapter also indicates that while there was opposition to the provincial programme from certain organizations including the provincial government itself, others like organized labour, medical consumer groups, etc. supported a prepaid programme.

An attempt has also been made to examine relations between the province and the federal government. The changed nature of federal-provincial relations led to what Joe Martin refers to as one of confrontation federalism[83] in which the major shared cost programmes including the ones relating to health came up for examination and revision.

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[83] Joe Martin, The Role and Place of Ontario in the Canadian Confederation, p. 33.

The passage of the Medicare Act in Manitoba had consequences, both intended and unintended, anticipated and unanticipated. These now bear some examination.

CHAPTER V

IMPLEMENTATION AND CONSEQUENCES OF THE MEDICARE DECISION

This chapter examines the main issues that arose at the implementation phase of the medicare plan within Manitoba. It begins by describing the steps taken by the government to put the scheme into operation. There follows an examination of the changing roles of the main actors in the health care policy system in the period after medicare. The consequences of the introduction of medicare will be examined under the following headings: (a) comprehensive, universal insurance coverage: (b) improved health: (c) rising costs: (d) effects on the medical profession: (e) effects on the health care system and (f) effects on the federal-provincial relations.

In order to finance the province's share of the cost of the Manitoba Medical Plan, the government instituted a monthly premium of $4.90 for single persons and $9.80 for families. The premium system was a tradition carried over from voluntary medical schemes and the hospital insurance plan that operated in Manitoba before the comprehensive scheme. Half the overall cost was covered by Ottawa.

It had already been mentioned that the medical profession which operated a voluntary scheme was opposed to a comprehensive medical care scheme. The profession favoured government subsidy to indigent persons. The doctors did not succeed in their quest for a voluntary scheme for Manitoba. They had to abide by the law of the land and sought to

mitigate the impact on their occupation through consultation with the government. The Saskatchewan experience, when the doctors of that province went on strike in 1962, was probably a deterrent for Manitoba doctors to take similar action, because the strike had produced a public backlash against the profession.

The Health Services Insurance Act, Section 115 (1) made provision for doctors to 'opt out' if they did not want to practise within the medicare plan. Doctors had sought the 'opt out' provision[1] as a means to gain some greater independence from government interference. They were at liberty to either practise completely within the medicare plan, billing the Health Services Commission for services rendered to insured persons, or practice outside the plan, billing the patient, who would be reimbursed by the government paying agency for the insured amount of the service. An opted-in doctor could only bill the patient for services not insured by the medicare plan.

Under the terms of the federal act, participating provinces were to meet four conditions to qualify for federal financial assistance. By 1969 Manitoba had met the criteria stipulated under the Canada Medical Care Act. Virtually the whole eligible population was insured for all

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[1] Department of Medical Economics, "Conference on Medical Care Insurance," Canadian Medical Association Journal 100 (January 1969): 130A.

medically required services of physicians. The essential details of the Manitoba Services Plan had been settled. The plan thus implemented would provide comprehensive coverage for hospital and medical services.

Medicare became law in Manitoba in July after the incumbent Progressive Conservative government of Walter Weir was defeated in the June 25th, 1969 general election by the New Democratic Party of Ed Schreyer. During the 1969 election campaign the N.D.P. put forward numerous reform proposals of which the reduction of medicare premiums was one.[2] As they promised in the election, the new government eventually removed the health insurance premiums effective from June 1, 1973.[3] The N.D.P. saw the premiums as regressive, that is, they did not correspond to ability to pay.[4] Elimination of premiums also reduced administrative costs, related to premium collection by the Health Services Commission. Finally, given that the premiums were not related to risks and the use of services,

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[2] T. Peterson and P. Barber, "Some Factors in the 1969 N.D.P. Victory in Manitoba", Lakehead University Review 3 (Fall 1970): 120-133.

[3] Manitoba, The Premier's Office, No Health Premiums After June 1st, 1973, March 30, 1977. See also, Manitoba. Statutes and Regulations, Manitoba Regulation 112/73, being a Regulation under The Health Services Insurance Act to amend Manitoba Regulation 70/72 amended by Manitoba Regulation 81/63 and 50/69, 1973. p. 358.

[4] Telephone interview with Mr. Saul Miller on 3/4/78. Mr. Miller was Chairman of the Cabinet Committee on Health, Education and Social Policy in the former N.D.P. government of Ed Schreyer.

they had no impact on the patient's use of services. The shift from premiums to taxes was accomplished by an Order-in-Council.[5]

On the other hand, the Progressive Conservatives saw the premiums as a deterrent to abuse of the system. They also saw them as providing a link between utilization of service and its costs. However, there is no empirical evidence to suggest that the premium system made Manitobans more or less conscious of the costliness of health care services.[6]

Under the N.D.P. administration, the Hospital Commission and the Manitoba Health Services Insurance Corporation ceased to exist. The hospital and health insurance programmes of these two organizations were amalgamated by an Act of the Manitoba Legislature in 1970.[7] The two programmes continued without interruption under a new commission known as the Manitoba Health Services Commission (M.H.S.C.).[8] Since the premium system had to be phased out and as such no bills would be sent out, it was considered expedient to merge

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[5] Interview with Mr. Doug M. Gourlay, P.C.,M.L.A. for Swan River on 9/5/78. Mr. Gourlay is Legislative Assistant to the Minister of Health in the P.C. government of Premier Sterling Lyon.

[6] Ibid.

[7] Manitoba, Statutes, The Health Services Act, 1970, ch. 81, especially Section 6. See also, The Winnipeg Free Press, 3 November 1970.

[8] Ibid. This Commission is responsible for planning, organizing and developing a balanced and integrated system of hospital and related health facilities and services throughout the province.

the two programmes to facilitate "functional and administrative co-operation between the two health programmes".[9] With reference to the relationship between the government and the doctors as a result of the merger, Mr. Miller indicated that,

> "the merger did not change the relationship between the government and the doctors. If there was any change at all, it was the medicare programme itself. The doctors operated a voluntary scheme before medicare and set their own fees. They argued among themselves about differential fees, and this didn't concern the government. When medicare was implemented, the doctors negotiated fee schedules with the Negotiating Committee of the Manitoba Health Services Commission on behalf of the government. Negotiations between the M.H.S.C. and the doctors brought bad relations, since they couldn't set their own fees as they did before medicare. They saw the end of their entrepreneural operation".[10]

Medicare has now been in operation for seven years. With all the turmoil and furor that went into the more than twenty-five years of debate prior to enactment, this hardly seems possible. A great deal of effort and money had gone into trying to fulfill the promise of medicare made to lay Manitobans and those segments involved in the delivery of health care including the medical profession.

It has already been mentioned that before Manitoba entered the federal scheme in 1969, only two-thirds of Manitobans had some

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[9] Interview with Mr. Saul Miller on 13/4/78.

[10] Ibid.

measure of insurance coverage against illness. This left one-third of Manitobans without physician care. Doctors' services for this group, especially those who were on welfare, were paid for by the state. The government of Manitoba spent a total of $28, 658, 133 or 17.7 per cent on health services out of a total provincial expenditure budget of $152, 862, 458 prior to medicare.[11] In the 1971 and 1972 fiscal years, immediately following the introduction of medicare, health expenditures rose to $28, 768, 183 or 18.3 per cent and $29, 267, 053 or 19.4 per cent respectively.[12] During the period from 1970 to 1977 there has been an increase of approximately 300 million current dollars in total government spending on health services.[13] Not all of this increased expenditure in the health field is due to medicare, of course. The cost of supporting the Manitoba Medical Care Insurance scheme has increased considerably since 1969, but its rate of growth has not been strikingly out of proportion to the growth rate of overall provincial spending for the same period. Moreover, some of the increases in health expenditures were the result of additional services - pharmacare, certain chiropractic and optometric; prosthetic and orthotic services including certain limb and spinal braces, when

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[11] These figures were released by Mr. Brian Gudmundson, Statistics Division, Manitoba Health Services Commission during an interview on 10/2/77.

[12] Annual Reports of the Manitoba Health Services Commission, 1970-72.

[13] Ibid, 1970 - 1977.

prescribed by a medical practitioner, for which the province received no cost-sharing benefits. The largest contributing factor to cost increases are hospitals, which represent approximately two-thirds of all government health care spending.[14] The existence of The Hospital Insurance Act, as has been noted, has led to a great reliance on hospitals. Within hospital budgets, approximately 75 to 80 per cent of costs are attributable to salaries[15] and the period under study witnessed increased unionization among hospital employees and rising wage demands.[16] The nature of the hospital product has also changed over time as the institutions have come to rely more extensively upon equipment and highly specialized personnel.

It should be noted that, not all the cost increases experienced since 1969 were due to the provision of 'free medicare', in fact most of the increases occurred in the hospital sector. This has been pointed out by the Canadian Medical Association in their submissions to government where they argue that physicians' salaries are not the main,

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[14] James Bennett and Jacques Krasny, "Hospitals caught in the health-care crunch", The Financial Post Perspective, 23 April 1977.

[15] Interview with Mr. Brian Gudmundson, Statistics Division, Manitoba Health Services Commission on 10/2/77.

[16] Ibid.

or even a significant factor, contributing to rising health costs.[17] It is pointed out by the Canadian Medical Association that doctors' net incomes have declined in recent years. It should be noted, however, that this line of argument ignores the important role of doctors in determining the extent, nature and duration of hospital utilization. By their discretionary actions on such matters, doctors influence directly hospital costs. In assessing the costs of medicare, therefore, it is necessary to retain some perspective on the cost experiences that have been encountered and to recognize the various contributing factors beyond the introduction of medicare itself.

Cost should not be the only determinant of health policy. The provision of high quality care was an equally important objective of the medical care plan. The concept of 'quality of care' is difficult to define precisely. Operationally, meaningful measurements of the concept are not readily available. Despite the conceptual and practical problems of operationalizing the concept, this does not deter the general public, physicians, hospital administrators and politicians from holding opinions and concerns about the quality of care provided by the health care system.

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[17] For more information on this line of thought by the Canadian Medical Association, see, "C.M.A. delegation at Parliamentary Hearing offers view on income restraint", Canadian Medical Association Journal 113 (November 22 1975): 1012A-1013.

A full examination of this issue is obviously beyond the scope of this thesis and any comprehensive judgement would require the assessment of various groups, including physicians, hospital administrators, economists and other social scientists. It is recognized, then, that what follows is only a partial assessment based upon some more obvious criteria associated with the medicare scheme.

(a) Comprehensive, universal coverage:

The Federal Medical Care Act had as a primary goal financial accessibility to health care. The criteria for federal funding of provincial plans were comprehensive and universal coverage, portability between provinces and public administration. The assumption was that if these criteria were met, access to medical services would not be determined by financial considerations. To what extent has this primary aim been accomplished?

With respect to the comprehensive coverage requirement, the plans of all the provinces and territories now provide almost complete coverage for medical practitioner services. Although in this regard medicare could be viewed as nearly a complete success, there have been many proposals that government insurance coverage should also be extended to include other forms of medical services such as private duty nursing, paramedical

services such as podiatrists, osteopaths, etc. While some provincial governments do provide additional benefits,[18] it could be argued that the federal cost-sharing arrangements should be extended to cover such services as drugs, dental care, etc.[19] Government health insurance has not yet eliminated the need for private coverage in the minds of some Manitobans. It is estimated that over two thousand people in Manitoba are still insured under a wide variety of private insurance plans for such matters as drugs, private-duty nurses, artificial limbs and other medical appliances and other aspects of extended health care and paramedical services.[20]

The other requirement was that provincial plans must be universal, which was defined as coverage of not less than 95 per cent of the province's population. In fact, one hundred per cent of the eligible population is now insured in Manitoba.[21] All provinces now exceed the 95 per cent

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[18] Manitoba residents, since 1974, receive additional benefits such as personal care services, prosthetic, orthotic and certain optometric and chiropractic services.

[19] For further details on this line of thought, see, Commons Debates, Vol. IV (11 May 1973), pp. 3666-7.

[20] Survey of Health Insurance Benefits in Canada (Toronto: Canadian Association of Accident and Sickness Insurers, 1976).

[21] Maurice LeClair, "The Canadian Health Care System", in National Health Insurance: Can we Learn from Canada? p. 36. One hundred per cent of the eligible population is also insured in Saskatchewan, Newfoundland, P.E.I., Nova Scotia, New Brunswick, Quebec, The Northwest Territories and the Yukon Territory. Virtually one hundred per cent in Alberta and British Columbia and over ninety-five per cent in Ontario.

requirement and there was only some temporary problems of coverage arising from eligibility clauses relating to new residents in Canada, Canadians travelling overseas and citizens moving between provinces within Canada. The latter was eliminated by an inter-provincial agreement in 1972,[22] under which all provinces provide up to three months coverage plus reasonable travelling time for persons moving to another province until the expiry of the waiting period in the new province of residence.[23]

(b) Improved health:

It was assumed that greater equality of access to health care among different income groups would lead to improved health of the nation. There are varying opinions on the actual impact of medicare in this regard. A National Health and Welfare Report of 1972 suggested that the poor were still not utilizing the system as much as they could for various reasons, such as the lack of a baby-sitter, the lack of transportation, no physician in their locality, etc.[24] The Manitoba Government White Paper on Health Policy of 1972 reported similar findings.

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[22] Ibid.

[23] Canada, Department of National Health and Welfare, Overview of the Canadian Health Care System, pp. 89-90.

[24] P. Ruderman, Economic Characteristics of Community Health Centres. A report to the Community Health Centre Project commissioned by Health and Welfare Canada (Ottawa: Information Canada, 1973), p. 2.

The White Paper noted that the health care system did not provide uniform standards since urban residents, in Winnipeg and Brandon for example, had access to a greater range of services due to the availability of specialists and sophisticated facilities that were lacking in rural areas.[25]

These findings confirmed an earlier study conducted in Saskatchewan. A study of the continuing relationship of Economic Class and Access to Physician Services under Public Medical Care Insurance, which examined comparative rates of utilization of medical services in Saskatchewan between 1963 and 1968, found that, "Even after six years of experience with medical care insurance, a disparity by income class still remains. That is, the lower income classes still display less accessibility to the services of physicians".[26] While it had been felt that economic and social class exerted an influence on the demand for health care regardless of the method of financing,[27] a subsequent study[28] indicated that, over a

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[25] For details of the Manitoba Government findings, see, Manitoba, Office of the Minister of Health and Social Development, White Paper on Health Policy, Appendix II (Winnipeg: Queen's Printer, November 1972), pp. 36-37.

[26] P. Ruderman, Economic Characteristics of Community Health Centres, 1973, p. 12.

[27] Robin F. Badgely, "The Impact of Medicare in Wheatville, Saskatchewan 1960-65", Canadian Journal of Public Health, 58 (March 1967): 101-107.

[28] H. Frazer and W. Clarke, "Unpublished study of the Yorkton, Saskatchewan Region", 1969.

period of more than five years of medicare, the behavior of different population groups tended to coalesce into a single common pattern of seeking physician care when ill health was perceived.

Much of the disparity was the result of physician preferences for location and community pressures for hospital beds. Thus, while one cannot dispute the statement of the Minister of National Health and Welfare, that, "with the introduction of the medical care programme, medical practice has become economically viable in any community with a sufficient population to warrant a doctor",[29] there is evidence to suggest that there remains a problem of mal-distribution of doctors between urban and rural areas.

There is a counter-argument to mal-distribution of doctors. Aaron Wildavsky offers a very interesting point in his study of The Political Pathology of Health Policy. He tells us that,

> "to say that physicians are maldistributed is to turn the truth upside down. For doctors to be in the wrong place they would have to be where people aren't and yet they are accused of sticking to the main population centres. If distant places with little crowding and less pollution far away from the curses of civilization, attracted the same people who advocate their virtues, doctors would live there too. Obviously, they prefer the amenities of metropolitan areas."[30]

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[29] Commons Debates, Vol. IV (11 May 1973), p. 3668.

[30] Aaron Wildavsky, "Doing Better and Feeling Worse: The Political Pathology of Health Policy", Daedalus 106 (Winter 1977): 109 - 110.

The rationale is that doctors are humans and citizens who have different desires and wants. In this context, they are not wrong to live wherever they want. Perhaps the government should offer the doctors some incentive in the way of money and make better facilities available to where people want to live. While such policies would not encourage all doctors to live where they do not want to, it would at least draw more of them to outlying regions.

Further research is required in this area in order to bring the facts to light. The available empirical research suggests that experience with a prepaid universal medicare plan lends to the emergence of a common usage pattern among different income groups, but this is partly conditioned by the availability of doctors where rural and urban disparities still exist, as has been shown. Therefore, it is very difficult to measure the precise impact of medicare on the quality of health care because of the many factors involved, namely, the difficulty of isolating the cause-effect relationships. There are indications that improved public health has resulted from medicare. For example, the infant mortality rate in Canada dropped significantly between the mid-fifties and the early nineteen seventies,[31] and this seems to be the result

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[31] Maurice LeClair, "The Canadian Health Care System", in National Health Insurance: Can we Learn From Canada? p. 43.

of the national health programmes, of which medicare is one.

If the previous section might be viewed as giving us the pros and cons for improved health, can access to more medical care be equated with being healthy? Wildavsky argues that,

> "more available medical care does not equal better health. The best estimates are that the medical system (doctors, drugs, hospitals) affects about 10 per cent of the usual indices for measuring health: whether you live at all (infant mortality), how well you live (days lost due to sickness), how long you live (adult mortality). The remaining 90 per cent are determined by factors over which doctors have little or no control, from individual lifestyle like smoking, exercise, worry etc. Most of the bad things that happen to people are at present beyond the reach of medicine". [32]

Wildavsky has reminded us of what we already know and perhaps have forgotten. All too often man forgets that in an important way, he is responsible for his own state of health. For example, we can avoid the crippling effects of automobile accidents by not driving when we are impaired.

How does this fit into medicine and public policy regarding health? Leon R. Kass in his study of Medicine and the Pursuit of Health indicated that,

> "health, understood as well-working wholeness, is not the business of only doctors. Health is, in different ways,

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[32] Aaron Wildavsky, "Doing Better and Feeling Worse: The Political Pathology of Health Policy", Daedalus 106 (Winter 1977): p. 105.

> everyone's business and it is best pursued if everyone regards and minds his own business - each of us his own health, the doctor the health of his patient, public health officials and legislators the health of the citizens."[33]

Kass's assertion needs no proof, it is an established fact. Even government regulations to force people to take proper care of themselves could be ignored. Medicare then exerts a curative approach which many will challenge. For example, Kass had suggested that there is a need to limit the doctors responsibilities based on the growing technology that could serve non-medical ends.[34] The medical profession must take the initiative in establishing the necessary boundaries. He suggested that,

> "medical licensurers should consider regulations barring its members to provide services such as cosmetic surgery etc. where the surgery does not aim to correct inborn and acquired abnormality or deformity."[35]

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[33] Leon R. Kass, "Medicine and the Pursuit of Health", The Public Interest 40 (Summer 1975): 33.

[34] Ibid.

[35] Ibid, p. 34.

But the problem of how to protect the profession's medical domain against unreasonable external demands still remains. Despite this, Kass has further suggested that "physicians should concern themselves with health as well - working wholeness and not only with the cure of disease".[36]

Kass is not saying that doctors should not be concerned with disease. In essence, he is indicating that doctors should be more concerned with medical educational programmes which will decrease the number of unnecessary visits to doctors' offices and emergency units.

It has also been maintained that the independence of physicians has led to mal-distribution. When the provincial governments established health care in the 1960's, they were unable to rationalize the existence of health resources and the geographic distribution of health manpower. James E. Bennett and Jacques Krasny have suggested at least four major areas where misuse of resources is predominant, namely, "health manpower deployment, health facilities, services and money".[37] These resources are usually based on the major population and economic centres because the demand for these services is largely influenced by its providers, particularly physicians. Rural areas were left

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[36] Ibid, p. 36.

[37] The Financial Post, 2 April 1977.

comparatively undersupplied. It has already been mentioned that there are more physicians and other categories of health manpower in the main population centres of Manitoba - Winnipeg and Brandon.

Duplication of facilities and services confined to major population centres also contributed to misuse of the health care system. For example, hospitals which account for approximately half of the provincial expenditure are virtually confined to urban areas of the province. Concentration of hospitals was the result of competition among local communities and citizen groups. The outcome was that neighbouring rural towns each had a hospital, where only one was required. Even in urban centres there were too many hospitals.[38]

Occupancy rate was also low as a result of duplication. In 1975, "twenty hospitals in Manitoba had only 55 per cent"[39] occupancy rate or less, presumably because of the distance involved to get to a hospital. Given that hospitals are labour intensive, each unoccupied bed was a waste of money if the hospital was staffed to its full bed capacity.

Furthermore, most complaints of illness could be treated by paramedics and similar trained health professionals. This has not

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38 Ibid.

39. Ibid.

been done. Hospital administrators in two Winnipeg hospitals indicated that both health professionals and the public have become hospital oriented.[40] The reason was the fact that hospitals were heavily utilized partly because in-patient treatment was the first access to hospital care insured through provincial government agencies before medicare. As a result attitudes and procedures which developed since the inauguration of the hospital programme led to the current utilization of acute care hospital facilities. Many patients believed that going to hospital was the only answer, no matter how small the problem was. However, if structural arrangements produced this situation, presumably changes in structure could shift or induce patients to less expensive care facilities. When this will take place, remains to be seen.

While there are mounting criticisms of abuse of the health care system, of which medicare is a part, a Gallup Poll taken in November 1977, showed that Canadians still ranked medicare first on the list of all programmes that they receive. Despite the criticism, no government will suggest that such a massive programme be abandoned.

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[40] Interview with Hospital Administrators of the Grace and Victoria General Hospitals in Winnipeg on 7/3/78.

(c) Rising costs:

The most pressing problem of Manitoba's health care system is the rapidly rising costs. The sources and consequences of rising health costs have been dealt with in the early part of this chapter. Medicare has clearly increased accessibility of medical services, which was one of the goals of the plan. But critics of rising costs have argued that prepaid medicare has led to patient abuse of the free treatment. This impact was summarized by Ruderman in his report on the community health centre concept.

> "Using the economic definition of effective demand as 'wants backed up by money', medicare has added to the previous demand those wants for physician services that were not previously backed up by money (particularly demand on the part of the low income population not eligible for welfare benefits) and the demand for more expensive types of elective care and surgery on the part of the population."[41]

Figures produced by the Department of National Health and Welfare revealed that the effect of medicare on increased utilization has been exaggerated. Although there was a significant increase during the first year of operation in each province, the rate of increase of utilization has been moderate and predictable. This increase can be attributable to social factors other than medicare.[42] A number of pre- and post- medicare

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[41] P. Ruderman, Economic Characteristics of Community Health Centres, 1973, p. 1.

[42] Maurice LeClair, "The Canadian Health Care System", in National Health Insurance: Can we Learn From Canada?, pp. 43-48.

studies show that there was not really any increase in the proportion of patients going to see physicians without reasonable cause.[43] These same sources also reveal that the rate of increase in medical costs since medicare is now rather less than it was for physicians' services prior to medicare.[44] The problem of cost escalation has been mainly in relation to hospitals, whereas the yearly increase in medicare has been running approximately as predicted.[45] These patterns are consistent with the experiences of Saskatchewan in the 1960's immediately following the introduction of its medicare plan. It can be concluded that while the Medical Care Act did increase health costs significantly immediately following its introduction, much of the increase was predictable and factors other than the introduction of pre-paid medical insurance appear to be more important in explaining rising health costs.

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[43] For details, see P. Ruderman, Economic Characteristics of Community Health Centres, 1973. See also, Gordon H. Defriese, "On Paying the Fiddler to Change the Tune: Further Evidence from Ontario Regarding the Impact of Universal Health Insurance on the Organizational Patterns of Medical Practice", Milbank Memorial Fund Quarterly 53 (Spring 1975): 117-193.

[44] Ibid. p. 48

[45] Canada, Department of National Health and Welfare, Overview of the Canadian Health Care System, pp. 155-160.

There have been charges made of unnecessary treatment by doctors under the fee-for-service system. Hans Kieferle, at one time Director of Research for the Manitoba Health Services Commission, charged that Manitoba doctors chose more expensive procedures for their patients and also used hospital beds as often as possible in order to obtain higher income.[46] While the so-called patient-generated health care items such as initial office calls, house calls and confinements, actually declined between 1970 and 1972, both the number and cost of physician-controlled service items, such as hospital calls and surgery for persons receiving treatment under medicare increased. For example, fees for one hundred patients increased by 3.6 per cent and total fees went up by 7.5 per cent, a total increase of $501,000 between 1970 and 1972.[47] Further, while the number of house calls for one hundred patients decreased by 27 per cent between 1970 and 1972 and fees for house calls for one hundred patients decreased by almost 32 per cent, total fees claimed by doctors for their services dropped only by 14 per cent.[48] In Churchill, where the staff of the Northern Health Unit was put on salary in June 1970, in-patient operations dropped by almost 54 per cent and radiology examinations by

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[46] The Winnipeg Free Press, 8 February 1972. See also The Winnipeg Tribune, 11 February 1972.

[47] The Winnipeg Tribune, 9 February 1972.

[48] Ibid.

34 per cent.[49] Since fee schedules were not changed between 1970 and 1972, it could be concluded that failure of totals to reflect average fees per one hundred patients was due to the choice of more expensive procedures.

It is interesting to note that criticisms on the medical profession have also come from within its ranks. For example, Dr. Jacques Genest, Director of the Clinical Research Institute of Montreal and Professor of Medicine at the University of Montreal, has charged that,

> "the medical profession has become so tired of continuously fighting what it considers inadequate and absurd decisions that many of its members have become deeply irritated and resigned to passive resistance and of doing their best under most difficult circumstances. As a result, motivation and devotion to patient care have been rapidly eroded."[50]

He further charged that,

> "In common with the rest of society and with the pervasive materialism and search for instant comfort, the medical profession has become increasingly bourgeois in its attitude. This had led to a severe decrease in societal participation and community service. Doctors have organized themselves into societies and federations which are in fact unions to protect interests and privileges more than they are 'learned societies'."[51]

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[49] The Winnipeg Tribune, 8 February 1972.

[50] The Toronto Star, 18 April 1978.

[51] Ibid.

Dr. Genest also indicated the impact of technology on the medical profession. He pointed out that,

> "advances in technology, along with many committees that investigate or certify the quality of care given to individual patients, have resulted in greater anxiety in doctors and a multiplication of unnecessary laboratory tests and radiological examinations. It is no surprise therefore, if medical management and diagnosis then are governed more by doctors' anxiety than by the exercise of clinical skills."[52]

It is not possible to prove or disprove Dr. Genest's assertion. The fact that these charges have come from a member of the medical profession itself, suggests that there is something wrong with the performance of some members of the medical profession that should be corrected.

The result of these criticisms was the establishment of a Medical Review Committee by agreement between the Manitoba Health Services Commission, the College of Physicians and Surgeons of Manitoba and the Manitoba Medical Association.[53] Between 1970 and 1972, twenty-seven doctors out of a total of 177 whose patterns of practice profiles and claims were examined, were asked to return funds to the Manitoba

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[52] Ibid.

[53] This Committee was started in 1956 by doctors to deal with doctors' accounts and standards of medical ethics and practice. When the Manitoba Medical Service was taken over by the government this Committee became by an Act of the Manitoba Legislature in 1967 part of the Manitoba Health Services Insurance Corporation and charged responsibility to deal with doctors' claims and patterns of medical practice. For details, see, Manitoba, Statutes, An Act Respecting Insurance of Residents of the Province in Respect to the Cost of Medical Services, 1967, ch. 36, especially Sections 36 and 37. See also, Manitoba, Statutes, Health Services Insurance Act, 1970, ch. H35, Sections 101 to 109; Manitoba, Statutes, The Health Services Insurance Act, 1970, ch. H35, Sections 35 and 36.

Health Services Commission for patient billings that were considered excessive by the Committee.[54] Between 1973 and 1976 the Committee examined patterns of practice profiles and claims relating to 265 doctors.[55] As a result, it asked 15 doctors to refund excessive billings to the Commission, and wrote letters to 59 doctors, requesting explanation for variation of patterns of practice from their peers.[56]

The validity of the criticism of the fee-for-service system is difficult to determine. The fact that the Medical Review Committee was initiated at the request of the doctors indicated that the profession was conscious of a potential or even an actual problem, which they sought to deal with internally rather than invite government interference. In 1956, Mr. C. B Germain, Professor of Acturial Mathematics at the University of Manitoba, was engaged by the Manitoba Medical Service as consultant statistician to study practice profiles and claims of doctors. In the same year, the Manitoba Medical Association Executive approved a report of the Manitoba Medical Association Economics Committee on the conduct of practice,

> "This involves standards and ethics of medical practice. Thus, if the Manitoba Medical Service perceives a medical member is giving unnecessary services or not conforming to the standard or

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[54] Annual Reports of the Manitoba Health Services Commission, 1970-1972.

[55] Ibid, 1973 - 1976.

[56] Ibid.

> common pattern followed by the majority of the profession, such an irregularity should be presented to and reviewed by a medical committee set up by the Board of M.M.S. It is highly undesirable to place disciplinary power pertaining to a professional group in the hands of a lay group."[57]

The statistician's report was presented to the doctors at a meeting on January 10, 1959. The report aroused a great deal of interest amongst the profession and the consensus was that the Manitoba Medical Service should proceed with its studies of patterns of practice. Reports of the Medical Review Committee were given at annual meetings of the profession thereafter. In essence, the present Medical Review Committee, established by an Act of the Legislature, is a carry over from what was initiated by the profession-sponsored programme.

(d) Effects on the medical profession:

The opposition of the medical profession to medicare was based on a series of concerns ranging from an ideological opposition to government involvement in health care to more detailed concerns related to methods of financing. Most doctors, and especially the leaders of the Canadian Medical Association, and the provincial medical associations, were convinced that public medicare would lead to crude government interference in the practice of medicine and in the doctor-patient

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[57] Manitoba Medical Service, Minutes of Meeting of the Medical Review Committee with the Executive of the Section of General Practice, September 14, 1965. (Winnipeg: Manitoba Medical Association, 1965).

relationship. It was felt that medicare would create medical manpower shortages and that Canada would cease to be an attractive country for physicians. This concern has not eventuated. The Minister of National Health and Welfare in a report to the Commons on May 11, 1973, said that,

> "decreased emigration and continuing high immigration of physicians from abroad and an increasing output from Canadian medical schools, have pushed Canada's doctor-population ratio down virtually to the target which the Royal Commission on Health Services in 1964 despaired reaching before 1991."[58]

Notwithstanding the Health Minister's assertion, Manitoba had experienced an exodus of doctors, especially in the last two years. There were 1,657 doctors practising in Manitoba as of September 30, 1977.[59] At the same time 132 doctors ceased practising in Manitoba - 38 went to the United States, 56 moved to other provinces, 19 went to the United Kingdom and Ireland and 13 went to unknown destinations and 7 died.[60] One hundred and four of the doctors were general practitioners, 93 of them had practised medicine in Manitoba for less than five years and another 22 had been in Manitoba for more than five but less than ten years. No specific reason had been given for this exodus. Dr. J. B. Morison, Registrar of the College of Physicians and Surgeons

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[58] Commons Debates, Vol. IV (11 May 1973), pp. 3667-3671.

[59] The Winnipeg Free Press, 3 November 1977.

[60] Ibid. See also, The Registrar, College of Physicians and Surgeons of Manitoba, Physicians Leaving Manitoba October 1, 1975 - September 30, 1977 (Winnipeg, October 1977).

of Manitoba, said attempts by the college to find out why doctors left the province proved abortive.[61] But, Dr. Morison indicated that,

> "the younger physician is very mobile and at all times there are large numbers of younger physicians arriving and leaving Manitoba -- the great majority departing have been in practice in Manitoba five years or less and, in fact, in the year ending September 30, 1977, over 92 per cent of the physicians leaving had been registered in Manitoba for less than ten years and more than forty - the latter group would be retirements and deaths".[62]

Dr. Morison further indicated that American graduates were the most likely to leave, although the actual numbers were very small. Asian graduates were least likely to leave, with only 7 out of 142 or 4.9 per cent leaving the province, followed by Manitoba graduates, with 5.2 per cent leaving.[63] Commenting on the statistics, Dr. Morison indicated that there is an adequate supply of medical talent in Manitoba, although this talent is not evenly distributed.[64]

The exodus has not affected the quality of medicare in the province. Doctors trained in Manitoba and in other provinces and countries make

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[61] The Winnipeg Free Press, 3 November 1977. Dr. Morison confirmed the newspaper write-up when interviewed by author in his Carlton office on 13/4/78.

[62] Ibid.

[63] Ibid. It is speculated that American graduates will leave in order to make more money. Asian graduates probably find working conditions and amenities more attractive in Canada, than elsewhere. According to Dr. Morison, Manitoba graduates move because it is traditional for Canadians to change places of residence every once in a while.

[64] Ibid.

up a good part of the losses. For example, in 1977, The Licensing Agency in Manitoba issued certificates of registration to 161 persons.[65] Sixty-six of the physicians involved in the registration graduated from the University of Manitoba; 24 came from Canadian Universities; 44 from the United Kingdom and Ireland; 4 from the United States; 1 from Europe; 11 from Asia; 3 from Australia; 1 from South Africa and 3 from Central and South America.[66]

The medical profession was concerned about the impact of medicare on physicians' remuneration. There seems to be clear evidence that in this respect the scheme did, in the short term, at least, work to the physician's benefit. A National Health and Welfare study shows that Canada-wide, the gross professional earnings of active fee-practice physicians rose by 8.3 per cent in 1969, 9.7 per cent in 1970 and 11.8 per cent in 1971.[67] These large increases in earnings of physicians have not been sustained since 1971. In fact, adjustments in fee schedules have been kept at a low level, partly it would seem, in an attempt to

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[65] The Winnipeg Free Press, 3 November 1977.

[66] Ibid.

[67] Canada, Department of National Health and Welfare, Earnings of Physicians in Canada, 1962-72 (Ottawa: Queen's Printer, n.d.), p. 19.

adjust medical earnings to what they were in 1971.[68] The increases in physicians' earnings in particular provinces in the first year of operation under medicare were quite spectacular, going as high as 38.9 per cent in Quebec in 1971, 35.7 per cent in Prince Edward Island in the same year, and 22.9 per cent in Manitoba in 1969.[69] The reasons for these increases relate to the fact that when universal payment was introduced, doctors began to bill for services previously provided on courtesy basis and bad debts were eliminated. Some allegations of over-billing by doctors were made and although some abuses undoubtedly did take place, it seems more sensible to view a short-term increase in medical incomes as a predictable effect of universal coverage.[70]

There is a counter argument. If medicare was not dominated by the medical profession because of their monopoly power, but left in the hands of qualified non-medical mento run it, medical costs could be reduced significantly. The doctors did not want medicare, but they

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[68] Ibid. See also, "C.M.A. delegation at Parliamentary hearing offers view on income restraint", pp. 1012A-1013.

[69] Canada, Department of National Health and Welfare, Earnings of Physicians in Canada, 1962-72, p. 19.

[70] D. D. Gellman, "Medicare, Medical Income Disparities and Fee Schedule Changes: Facts, Fallacies, Problems, and Positions", Canadian Medical Association Journal 105 (September 18, 1971): 656-657.

realized that with their monopoly power on committees and boards they could reduce the restrictive effects on their earnings. It is alleged by Malcolm Brown, that the fee-for-service system had made it possible for doctors to increase their earnings by providing patients with extra, unnecessary services such as removing corns (which could be done by a paramedic), asking more patients to come back for follow-up visits when they are not essential, etc.[71]

There are two sides to Brown's assertion. If doctors increased their earnings by offering unnecessary services, it may also be the case that patients demand or do not resist such extensions of service. Since services were free more people were inclined to seek medical attention when it was not necessary. It is also hard to define what makes a 'service' unnecessary. Brown's assertion cannot be proven or disproven without detailed examination of the services rendered by doctors and the services received by the consumer.

Finally, the whole medicare debate has resulted in considerable reappraisal by the medical profession of its role and relationships with government and the public. The establishment of medical care programmes by the various Canadian governments was a challenge to the medical profession and the fee-for-service system. Under the conditions of the

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[71] For more details on this line of thought, see, M. C Brown, Medicare and the Medical Monopoly", Canadian Forum 54 (April 1974): 5 - 9.

national medical care insurance, governments were faced with pressure to control costs on one hand, and on the other with an escalating rate of increase in the volume of claims upon the insurance plans. Carolyn Tuohy, in her study of "Medical Politics After Medicare", suggested three choices for governments which wished to maintain a given level of coverage to adopt,

> (1) the government may negotiate with the suppliers of medical services in an attempt to reduce or at least to avoid further increase in their price per unit of service,
> (2) it may either directly or through professional channels exercise regulatory power over the volume of medical services provided, and
> (3) it may seek to effect, through both legislative and organizational change, a re-allocation of some medical functions to less highly trained and less expensive personnel.[72]

The government of Manitoba has utilized the first two of these options. With regard to the first option, approximately 95 per cent of physicians in Manitoba have found it economically rational to accept the fee-for-service as the basis for payment for their services. The other 5% of the doctors practising outside the programme, billed their patients direct. Having established the fee-for-service principle,

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72 Carolyn Tuohy, "Medical Politics After Medicare", Canadian Public Policy 2 (Spring 1976): 193.

the Negotiating Committee[73] on behalf of the Manitoba Health Services Commission, which represents the government, negotiates the level of fees with the Manitoba Medical Association. Government involvement into the medical profession's domain has met with resistance. While the battle over the defense of discretion over the price of services rendered had been lost, the opportunity of 'opting out' of the government insurance plan still remains in order to retain professional discretion.

The province's second option has involved the establishment of a Medical Review Committee to investigate the practices of doctors whose billings are disproportionately large within their particular specialty.[74] While it sought to limit the volume of services provided by the individual doctor, as a cost-saving device, it did not limit the number of doctors who could practise medicine in the province. According to Dr. Morison, "immigrant physicians who met the licensing requirements of the College of Physicians and Surgeons of Manitoba were welcome into the province if

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[73] This Committee was founded in 1973. (Interview with Information Officer, M.H.S.C. on 27/3/78). Its duties include (a) schedule of fees to be paid by the Commission to medical practitioners in respect of medical services rendered to insured persons, (b) deals with terms and conditions relating to the application of the schedule of fees in respect of medical services rendered to insured persons, and (c) methods of payment to medical practitioners of benefits payable in respect of medical services rendered to insured persons. Members of the Committee are: Executive Director, Assistant Executive Director, Director of Insurance, Claims Manager, Economist, Management Committee of Cabinet Staff Relations Director with a negotiating background plus provincial overview and a legal counsel.

[74] The history of this Committee has already been referred to in this thesis.

they satisfied immigration regulations. These immigrant physicians were posted to remote areas of the province where Canadian and American physicians didn't want to live."[75]

With reference to the third option, the Department of Health and Social Development is experimenting with the establishment of Community Health Clinics providing for capitation payment mechanism.[76] This is an attempt to lower unit costs of medical services.

The pursuit of each of these functions has evolved the formal introduction of lay participants into the structure of policy-making. For example, two of the seven members of the Medical Review Committee are laymen , chosen and appointed by the Health Services Commission.[77]

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[75] Interview with Dr. Morison on 13/4/77. Mr. Saul Miller, Chairman of the Cabinet Committee on Health in the former N.D.P. government also indicated that his government was not opposed to the admission of immigrant physicians when interviewed on 3/4/77.

[76] Manitoba, Office of the Minister of Health and Social Development, White Paper on Health Policy Appendix I (Winnipeg: Queen's Printer, November 1972), pp. 23-25, 137-141. See also, Dr. T. H. Tulchinsky, Associate Deputy Minister, "Regionalization - The Manitoba Experience", paper presented at the annual meeting of the Canadian Public Health Association, Winnipeg, Manitoba, 25 April 1973. See also, The Winnipeg Tribune, August and October 1972 and The Winnipeg Free Press, 1 December 1973.

[77] Annual Reports of the Manitoba Health Services Commission, 1969 - 1976.

While the government has challenged the physician's discretion over the price and volume of his services, it has not challenged the power of the profession over the allocation of functions among health care personnel.

The Manitoba Medical Association charged that since 1942 when the doctor-sponsored Manitoba Medical Service was founded, Manitoba physicians practised medicine in a restrained relationship with government.[78] The Manitoba Medical Service was established by the medical profession as an insurance programme. Physicians participating in the plan did so with three particular restraints,

(1) M.M.S. had to answer to the general public as far as payment of premiums for coverage was concerned,

(2) the physician contracting with M.M.S. guaranteed to accept the fee paid for a particular service as payment in full and

(3) participating doctors were 'locked into' the plan, fees had to be contained in order to keep premiums within the affordable limits of low-to-medium income people.[79]

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[78] Dr. C. E. Abbot, Past President of the M.M.A., "Medical Incomes and Government Restraint Measures: The Manitoba Experience", report to the Conference on the Professions and Public Policy, Toronto, 16 October 1976, p. 4.

[79] Ibid.

When Manitoba entered the national programme in July 1969, the Manitoba Medical Service plan was terminated. Fiscal control passed into the hands of the provincial government. Government-operated medical insurance resulted in the medical profession having to negotiate with the government to develop a schedule of fees to be paid for insured services, which according to the profession, was a restraint on their incomes.

The first full year of universal prepaid medical care insurance in Manitoba saw the average opted-in physician's income go up by a sizeable amount. The reasons were: (a) a slight increase in fees in 1969 to launch medicare, (b) the fact that the physician began getting paid for work previously done at no charge, (c) the physician had few, if any, unpaid accounts to deal with and (d) a situation where the compulsory prepaid programme resulted in more people going to see the doctor, thereby increasing his or her workload.[80] Physicians participating in the Manitoba Medical Plan received no increase in fees for insured services between 1969 and 1974 because the government refused to grant any increase. During this period, the average medical practitioners gross earnings from the plan reached a peak in 1970 -

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[80] Ibid, p.6.

the first full year of the programme and remained relatively stable for the next three years. However, costs of practice from 1969 through 1973 went up approximately 40.3 per cent for the average physician and the purchasing power of the fee dollar, in 1969 terms, declined by almost 14 cents.[81]

In January 1974, after two years of negotiations, an agreement with the Manitoba Health Services Commission was concluded. The M.H.S.C. recognized the association as the sole and exclusive bargaining agency for all medical practitioners participating in the plan. This provided the opportunity for an input into health planning, established an appeal procedure for participating physicians and provided for an increase in fees of 6 per cent in 1974 and 5 per cent in 1975.[82] Conclusion of the agreement was not easy. Relations between the profession and the government had become so strained over the previous four years that physicians throughout Manitoba were preparing to close their offices and withdraw all but emergency medical services when the agreement was finally reached.

Between 1974 and 1975 medical incomes turned out to be even more

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[81] Ibid. See table on page 152 . Figures were obtained from the Manitoba Health Services Commission Annual Reports for the years 1969 - 1976.

[82] The Medical Post, 23 December 1975. These fee increases were the first general increases since 1969.

restrained than anticipated for the 95 per cent of Manitoba physicians participating in the plan because of double-digit inflation and on-going escalating expenses of practice. By the end of 1975, the average opted-in physician's gross earnings from medicare had increased by 9.3 per cent from two years earlier, but costs of practice went up by 14.8 per cent on the average in those two years and the purchasing power of the fee dollar slipped another 17 cents in 1969.[83] Despite this erosion of doctors' incomes, a request by the M.M.A. for an adjustment in fees to compensate for the effects of inflation was rejected.

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[83] See Table on page 152.

AVERAGE NET INCOMES OF PHYSICIANS PRACTISING IN THE MEDICARE PLAN, MANITOBA, 1969-1976.

YEAR	GROSS MHSC PAYMENTS	ESTIMATED EXPENSES	(RATIO)	NET (CURRENT)	% INC. (DEC.)	NET (CONSTANT)[4]	PURCHASING POWER 1969 = $1.00
1969	39,400[1]	14,060	(35.7)	25,340		25,340	$1.00
1970	48,065	16,552	(33.7)	31,513	24.4	30,536	.969
1971	48,025	15,052	(31.3)	32,973	4.6	31,555	.957
1972	47,010	18,420	(39.2)	28,590	(13.3)	26,360	.922
1973	47,535	19,727	(41.5)	27,808	(2.7)	24,110	.867
1974	49,765	20,603	(41.4)	29,162	4.9	22,834	.783
1975	51,965	21,800[3]	(42.0)	30,169	3.4	21,925	.697
1976	56,010[2]	23,500	(42.0)	32,510	7.8	21,107	.649

SOURCES: MHSC Annual Reports, 1969 - 1976
1973 & 1974 MMA Expense surveys (Used to calculate Gross income/expense ratios).
Earnings of Physicians in Canada, 1962 - 1972

1 Estimated to reflect full year since MHSC began operations April 1, 1969. Estimate based on gross income from taxation statistics as reported in "Earnings of Physicians in Canada" published by Department of National Health and Welfare.

2 Estimated to reflect recent 9.15% increase in benefits. 2.15% was deducted to allow for increased utilization and physician population.

3 Increase of 10% assumed

4 Based on inflation rate for Winnipeg (yearly average CPI - all items).

The Manitoba Medical Association also charged that the Anti-Inflation Board programme put limitations on doctors' incomes. The government stated that doctors who received payments from the medicare program were not allowed to increase their incomes by more than $2400 because of the anti-inflation guidelines.[84]

On January 14, 1976, Mr. L. Desjardins, the Minister of Health and Social Development, instructed the Manitoba Health Services Commission to end negotiations with the Manitoba Medical Association and terminate the agreement in force with the Association after negotiations to revise the existing agreement failed.[85] At the same time, he unilaterally established a 1976 fee schedule for insured services which involved an increase of 9.15 per cent in the total payment made for medical services in the previous year.[86] In essence, the Minister instituted a programme of discounted fees in accordance with A.I.B. guidelines, for services rendered after a physician reached a certain point in gross receipts from the medicare plan. The 1975 fees were increased by two percentage points - one percentage point was earmarked to offset increased overhead costs, the other percentage point was applied to net income improvement.

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[84] The Financial Post, 20 February 1976.

[85] The Medical Post, 20 January 1976. This point is also discussed in The Winnipeg Tribune, 17 November 1976.

[86] See, News Release - Manitoba, Office of the Minister of Health and Social Development, "Revised Fee Proposal to Doctors" (Winnipeg, 29 December 1975).

In December 1976, the Manitoba Medical Association concluded an agreement with the Manitoba Health Services Commission on behalf of the government on the following fee adjustments for 1977,

(a) that the discounted fee method of payment be discontinued with effect from January 1, 1977,

(b) that the agreed upon 9.15 per cent increase for 1976 be applied to establish a 1976 base,

(c) that a 7 per cent adjustment be applied to the 1976 base, to be effective January 1, 1977.[87]

Since fee schedules are negotiated annually, concluding a fee schedule for 1977 did not prejudice the Association's right to further negotiations in the coming years.

The profession's concerns about governmental interference were not related solely to incomes, but also involved the fundamental issue of who was to control the delivery of medical services - who was to decide what services would be paid for, where and when they may be provided (hospitals, offices, etc.) and by whom (doctors, nurses, etc.).

There is no specified negotiating process in Manitoba because the pressures and objectives seem to change each year. Consequently, although there is a basic pattern such as face to face discussions and mutual work at the various staff levels the process has differed from year to year.

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87 Manitoba Health Services Commission Schedule of Benefits, by T. R. Edwards, Chairman (Winnipeg: Queen's Printer, 1976), pp. 1-142.

(e) Effects on the health care system:

This section examines whether medicare has resulted in distortion in the use of medical services. It has been argued that in covering only services rendered by physicians and surgeons, The Medical Care Act has resulted in a concentration on this source of service as opposed to the use of other health personnel whose services are less costly, eg. nurses. It is suggested that this led to a negative effect on the professional development of these other groups and an increase in costs through a bias towards the use of the most expensive personnel.[88] This argument applies mainly to criticisms of the hospital insurance programme, which it is argued encouraged the over use of in-patient hospital services.[89] Cost considerations made the Federal Government serve notice in May 1973 of the placement of a ceiling on costs beginning from 1976.[90] There seems to be little disagreement that the existing arrangements were somewhat inflexible and led to over-emphasis on the role of the doctor.

Implicit in this point of view was the assumption that the type and

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[88] Peter Aucoin, "Federal Health Care Policy", pp. 68 - 69.

[89] P. Ruderman, Economic Characteristics of Community Health Centres, 1973. p. 2.

[90] For details on this matter see, Canada, Office of the Minister of Finance, "Notices of Ways and Means Motions", Budget Speech Monday June 23, 1975. pp. 17 - 18.

source of financing determined the type and nature of the organization of medical care.[91] Experience seemed to indicate that although universal health insurance was a necessary step toward the provision of full health care coverage for the entire population, it was not in itself sufficient to stimulate or determine the type of organization of health services that was required to make this commitment possible. Vincente tells us that when national health programmes were adopted, they did not lead to changes in the types of medical practice in the delivery system, but instead strengthened the existing patterns and types of delivery system. In those circumstances the insurance mechanism "acted more as a consolidating force than as a stimulant for change in the organization of medical care."[92] Although there is no supportive empirical evidence, it seems the insurance mechanism in Manitoba has adapted itself to the existing prepaid and fee-for-service systems and complete coverage of the population was assured. But the organization of services and patterns of consumer utilization characteristic of these systems of medical practice have not experienced major change. Defries then concluded that, "it may not be possible to alter fundamental aspects of health care delivery systems through change

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[91] Earnest W. Saward and Merwyn R. Greenlick, "Health Policy and the Health Maintenance Organization", Milbank Memorial Fund Quarterly 50 (January 1972): 147 - 174.

[92] Vincente, Navarro, "National Health Insurance and the Strategy for Change", Milbank Memorial Fund Quarterly 51 (Spring 1973): 224.

in the financial mechanism alone. A health insurance mechanism may, in this sense, be a new way to pay the fiddler without changing the tune".[93] Thus, the fee-for-service system was not primarily intended to change the organization of medical care, but to adapt the system of funding to the needs of the already existing delivery system or at simplifying the administration of the health insurance system. This is, however, an area where further research is needed.

In response to the demand for ways and means to curb the rising costs of health care, the President of the Canadian Medical Association, among many others, suggested the introduction of deterrent fees as a means of restraining health care utilization.[94] The most common criticism is the fear that such fees would deter people who need the medical care the most - namely, the poor. Deterrent fees were also opposed because they tended to place the onus on the patient to determine when he is ill enough to warrant services of a physician. Such fees, it is feared, would deter individuals from seeking advice from doctors at an early stage of illness and would mean higher costs later when the illness becomes very serious. It must be remembered that the current

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[93] Gordon H. Defriese, "On Paying the Fiddler to Change the Tune", p. 118.

[94] The Toronto Star, 19 February 1975.

medicare programme came into effect to assure equal access to health care, irrespective of the individual's capacity to pay. While this has been the primary objective of many health care policies, implicitly if not explicitly, hardly any studies have been made to determine how well this objective has been met by Canada's existing system.

It is important to note that deterrent fees are often recommended to reduce unnecessary utilization, but not needed care. Government agencies have the ability to shed some light on the question through compilation and analysis of patient utilization profiles. To date no such study has been made public.

A study of the Saskatchewan experience with deterrent fees for physicians and hospital services between 1963 and 1968 showed a considerable reduction in the consumption of medical services by the poor.[95] Depending on the definition of 'the poor' that was used, the reduction in use ranged from twelve to twenty-four per cent. The cost-savings that did occur were, in fact, of very short duration. While these findings were obviously interesting, one question remained unanswered: was the reduction in use a reduction in the unnecessary use of health care services? The Saskatchewan studies did not answer this

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[95] R. G. Beck, "On the Effects of Co-payment on the Poor", Journal of Human Resources 9 (Winter 1974): 129 - 141.

question. Indeed, it may not be possible to get a definitive answer to the question, other than through a most rigorous experimental control study. However, the lack of evidence of abuse, questions about the basic behavioural assumptions implicit in the proposal and the little evidence that exists, leads one to doubt that the introduction of deterrent fees would achieve the basic objectives of its advocates in Manitoba.

(f) Impact on Federal-Provincial relations:

Medicare had effects beyond the health care system itself. In particular, the passage and implementation of The Medical Care Act was an important episode in federal-provincial relationships. Conditional grant proposals such as medicare have a history in Canadian federalism dating as far back as 1912.[96] However, apart from Quebec, there had been very little principled provincial resistance to such grants prior to the 1960's.[97] During the 1960's there was increasing anxiety about the implications of such grants, particularly insofar as they were restricting the autonomy of the provinces in matters within their jurisdiction. This anxiety was focused by the medical conflict. The 'take it or leave it attitude' of the Federal Government when the scheme

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[96] For a comprehensive discussion on shared-cost programmes, see, D. V. Smiley, Canada in Question: Federalism in the Seventies (Toronto: McGraw-Hill, 1972), pp. 114-153.

[97] Ibid, p. 136.

was proposed; the lack of provisions for payment of a fiscal equivalent to non-participating provinces; the action of the Federal Government in levying the two per cent Social Development Tax in the 1968 budget; all these factors generated provincial hostility to the Federal Government. G. R. Weller in his study of Ontario's medicare programme tells us that, "the manner of the introduction of medicare and the crisis it created in health not only served to enhance provincial pressure for more tax room but also generated a strong desire on their part to gain greater control and resist further federal spending programmes".[98]

At the Constitutional Conference[99] held in Ottawa in June 1969, the Federal Government made proposals toward the constitutional clarification of its power to expend funds of matters other than those to her under Sections 91 and 95 of The B.N.A. Act. In a paper presented to this conference, the federal government made it clear that it would use its spending power only when there was a national consensus[100] expressed by a qualified majority of the provinces.

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[98] G. R. Weller, "Health Care and Medicare in Ontario", in <u>Issues in Canadian Public Policy</u>, p. 94.

[99] For further information, see, Canada, Federal-Provincial Constitutional Conference, February 10-12, 1969. <u>Proceedings</u> (Ottawa: Queen's Printer, 1969), pp. 151-201.

[100] For the determination of the 'national consensus' see, Canada, Federal-Provincial Grants and the Spending Power of Parliament, <u>Working Paper</u> (Ottawa: Queen's Printer, 1969), pp. 40-44.

In general terms the federal policy objectives conformed to the provincial objectives, but numerous problems were experienced as a result of the specifics of the shared-cost arrangements. The rigidities of the criteria for cost-sharing resulted in tension and charges of inequities. There were complaints that provincial priorities were distorted because of the availability of federal funds for certain specific health services and not for others. The formula offered minimal returns to provinces for cost-saving achievements. It has, indeed, been widely noted that cheaper substitutes for expensive hospital care services such as nursing homes and home care programmes, were discouraged by the federal-provincial cost-sharing arrangements.[101]

The Federal Government had the problem of open-ended commitment to pay provincial bills - the formula did not supply the provinces with sufficient incentive to restrain costs. In the budget of June 1975, the Federal Government served notice that, through an amendment to the Medical Care Act, beginning in the fiscal year 1976/77 a ceiling would be placed on the per capita rate of growth of federal contributions on medical costs. This ceiling would be 13 per cent in 1976/77, 10.5 per

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[101] For a summary of complaints, see, Ontario, Department of the Treasury and Economics, Supplementary Actions to the 1975 Ontario Budget, July 7, 1975.

cent in 1977/78 and 8.5 per cent in 1978/79 and subsequent years.[102]

In the same budget, the Federal Government gave a five year notice to the provinces of its intention to terminate the existing cost-sharing arrangements. This represented the conclusion of a series of federal-provincial negotiations. The federal government was concerned about the rapidly growing expenditures in the shared-cost programmes, for which it had no control. The provinces were in general agreement with the federal position that a measure of control was inevitable, but for their part, they wanted more provincial autonomy in the major joint programmes. The end result was a system which encouraged provincial autonomy, reduced federal control and auditing, and reflected a new federal priority by providing for equality in the per capita payments. The objective of the change was to force the provinces to implement cost-saving changes in their health care systems and to speed up the federal-provincial efforts to come up with alternative financial arrangements to replace the open-ended and rigid cost-sharing arrangements.[103]

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[102] For details of the Budget Speech, see, Canada, Office of the Minister of Finance, "Notices of Ways and Means Motions", Budget Speech Monday June 23, 1975.

[103] For details see, Canada, Department of Finance, Budget Highlights and Supplementary Information, June 23, 1975. (Ottawa: Queen's Printer, 1975), pp. 15-17.

New fiscal arrangements between the federal and provincial governments concluded in 1977, were the result of the Federal-Provincial Fiscal Arrangements and Established Programmes Financing Act, passed by the House of Commons on March 23, 1977 and given royal assent on April 1, 1977.[104] The new arrangements which cover the period 1977 to 1982,[105] replaced a previous five year agreement, the Fiscal Arrangements Act of 1972,[106] which expired March 31, 1977. Implicit in the new Act was the basic principle that fiscal resources and administrative responsibility on shared-cost programmes should be shifted to the provinces. The most contentious issue of the federal-provincial fiscal negotiations was the termination of the government's matching, open-ended contributions for the hospital, medical and education programmes. They have been replaced by a basic transfer of "13.5 tax points to the provinces, plus an equivalent amount of cash to be indexed to the growth of the economy and not to the growth of provincial expenditures as previously".[107]

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[104] Canada, Laws, Statutes etc., Federal-Provincial Fiscal Arrangements and Established Programmes Financing Act 1977, 26 Eliz. 2, ch. 10, especially Sections 26-28.

[105] George E. Carter, "Financing Health and Post-Secondary Education: A New and Complex Fiscal Arrangement", Canadian Tax Journal XXV (September-October 1977): 537.

[106] For details, see, Canada, Laws, Statutes etc., Federal-Provincial Fiscal Arrangements Act 1972, 21 Eliz. 2, ch. 8, pp. 63-95. This programme was initiated to protect provinces from any revenue decline resulting from major changes introduced in the federal tax structure at any time.

[107] Les Kom and Richard Simeon, "Fiscal Relations", The Federal Year in Review (September 1976 - September 1977): 20

The Federal Government argued that the Revenue Guarantee begun in 1972 at the time of the changes to The Income Tax Act had become very costly, with payments to the provinces rising from "$150 Million in 1973 to $600 - $900 million in 1976 and that there was no longer any revenue uncertainties resulting from tax reforms,"[108] There was strong opposition from the provinces to the ending of these payments. The provinces, especially the have-not ones, argued that the associated equalization to the per capita national average was inadequate. They also argued that tax points should be equalized up to the level of the top yielding province. Manitoba's former Premier Ed Schreyer, who was also Minister of Finance in 1976, said that he was concerned about the cost sharing of the medicare programme between the province and the federal government. He was also concerned about the changed revenue guarantee provision from Ottawa which threatened to reduce Manitoba's transfer payment by $20 to $25 million.[109] The provinces, however, were compensated by the transfer of "two points by the federal government of its personal income tax to protect them for a year for any future change in the federal tax structure."[110] However, 70 per cent of personal income tax still goes

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[108] Ibid, p. 19

[109] Saywell, Canadian Annual Review, 1976, p. 237.

[110] Les Kom and Richard Simeon, "Fiscal Relations", The Federal Year in Review, (September 1976 - September 1977): 19.

to the Federal Government.[111]

It appears that even if the two levels of government could agree on the general properties of the new arrangements, the key economic issue still will be the total dollar flow from the federal to the provincial coffers. The provinces will be loathe to receive any less than they can expect under the current scheme. On the other hand, the Federal Government would be loathe to yield any more than it has to pay under the current system. The provincial minimum is the federal maximum. This leaves very little room for negotiation.

This, in itself, should not be fatal to the working out of a new arrangement. In October 1975, Marc Lalonde, Minister of National Health and Welfare, stated that, "the federal government will work out new agreements which will provide for care which is relatively more economical but no less effective".[112] He further said, "we want to move towards greater emphasis on lower cost alternatives - among the subjects so far discussed have been nursing home care, ambulatory care centres and home care - so that patients requiring less than general hospital care can be suitably looked after without financial penalty to themselves."[113]

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[111] Saywell, Canadian Annual Review, 1976, p. 237.

[112] Saywell, "Health Care", Canadian Annual Review 1975, p. 60.

[113] Ibid. See also, George E. Carter, "Financing Health and Post-Secondary Education: A New and Complex Arrangement", Canadian Tax Journal XXV (September-October 1977): 541.

It should be noted that the New Fiscal Arrangements Act (covering a period of five years), which is already referred to here, has offered an amount of flexibility to the provinces, which enables them to recognize their priorities. By virtue of this new arrangement, the provinces now receive funds from the federal government on an unconditional, per capita basis. The new arrangement has therefore, addressed the total health system rather than specific sectors and has simplified administrative arrangements between the two levels of government.

However, the key political issue has been, and remains, the desire of the provincial governments to maintain and to recoup from the Federal Government their autonomy over health matters. Just how and when this thorny issue of the Federal-Provincial financing of health care services will be resolved remains to be seen. In any case it can be expected that the provincial governments will have to bear a higher proportion of the operating costs of the health plans. How great the increase will be depends on the success of the effort to contain growth in expenditure.

This chapter has presented the consequences that emerged when Manitoba entered the federal medical care scheme, with an indication of the organization and financial arrangements that were adopted in the initial phase. The role of the main actors in the post medicare period was also examined. Under the prepayment plan, the doctors were faced with a new situation in which a third party was responsible for payment

to the doctors for insured services rendered. While the third party was not acquainted with the circumstances surrounding each case, they wanted to know what the services were, when and where rendered and to whom, before payment was made. Henceforth, the doctors were called upon not only to verify the nature of their services, but to institute more accurate financial and accounting records, all of which tended to force them to become more concerned with the organization of their services. It is this legislative control through the provincial commission which the Manitoba Medical Association disagreed with. They feared that the fee-for-service mechanism might be used to impose conditions of practice which would restrict professional autonomy. Final budgetary control would lie with the provincial government, and such control might be used to question the behavior of doctors. This possibility was not overlooked by the Hall Commission on Health Services which attempted to provide safeguards for the professional autonomy of doctors practising within the universal medical care insurance scheme. The Hall Commission recognized the ultimate power of the democratically elected government when it stated,

> "Organized medicine is a statutory creation of legislatures and Parliament. When the state grants a monopoly to an exclusive group to render an indispensable service it

> automatically becomes involved in whether those services are available and on what terms and conditions."[114]

With rising fees and volume of care, the possibility of some form of cost control with resulting controls for both the manner in which medical services are delivered and the quality of these services seems inevitable. Thus the fears of government control over some essential elements of today's medical practice may be realized.

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[114] Hall Commission, Vol. II, p. 11

CONCLUSION

The main objectives of this study were: (a) to present an analysis of the pre-medicare period in Manitoba; (b) to examine the issues that led to the final phase of the implementation of medicare and (c) to evaluate the role of the various participants involved. In chapter two it was shown that in the pre-medicare period, while private medical care insurance plans had grown in number, there were gaps in their coverage. The Medical Care Act was therefore, the culmination of a developing social philosophy. Gradually, the individualistic philosophy of the nineteenth century had been replaced by governmental responsibility for those who were dependent or who were unprotected against certain economic risks. The concept of dependency, accelerated by the depression and the two World Wars, changed into acceptance of a broad doctrine of social rights. The availability of free education for all, without a means test, was one such goal; comprehensive free medical care was another.

The final phase of the implementation of medicare came after the Report of the Royal Commission on Health Services was released in 1964. The Report created widespread interest in Manitoba and the other provinces. Reservations were expressed in respect to the central recommendation of a comprehensive, universal programme of health services. It would be hard to say exactly what influence the health insurance recommendations had on the provincial policy-makers, but the Report

certainly made a substantial impact in urging far-reaching legislative measures, and the political leader with his ear to the ground would not miss the generally favourable public reaction. Hence, in mid-March 1967, the Manitoba Government assessed the principles laid down by Ottawa and introduced Bill 68 which became law in 1969 during the Conservative administration.

In chapter four an attempt was made to assess the influence of the major groups involved in the discussions on medicare. A complete and precise weighing of the role of various actors had been impossible because of the secrecy surrounding the process by which important decisions were reached. There was strong opposition from the medical profession and also from the provinces when the federal government announced a programme of universal compulsory medicare to go into effect on July 1, 1967. Like the National Canadian Medical Association, its provincial branch, the Manitoba Medical Association opposed the compulsory nature of the legislation as an "infringement on a learned profession by government." In its lobbying campaign against the scheme, the medical profession had a number of advantages not readily available to many other groups, namely, great wealth, status, and expertise. Despite these advantages, attempts by the medical profession to block the legislation failed, mainly because the federal government was electorally committed to a scheme which had wide public support.

The provinces opposed the programme because they felt they did not have the money to pay for the services. There was little that they could do to prevent medicare from becoming a reality. Opposition to the medicare programme also came from within the federal cabinet itself. It was so great that in early September, just four months after the original announcement, the date of commencement was postponed until July 1, 1968. One point was clear. The Federal Government had taken a decision to go ahead with medicare. In spite of the almost unanimous opposition of the provincial governments, they had no alternative but to adopt the federal scheme.

The study also examined issues faced by Manitoba in the seventies. Although events in health had been at a disequilibrium for some time, very few noticed this trend. As a consequence, the issues appear as sudden occurrences directly related to the introduction of medicare. It should be noted that, medicare was just one of a series of events that helped to reveal some of the real inadequacies of the current health care system.

The principal findings of chapter five were that escalating costs will continue if nothing is done to combat this trend. Further, there will be continuous conflict between the providers of the service and the provincial government. As already mentioned in chapter five, attempts by the government to restrain costs by holding down fee increases have met with opposition. The medical profession had attempted to protect a

method of renumeration over the pricing policy of its services and also retain control of sanctions which allow it to enforce this policy. The profession has maintained that fee schedules should not be interpreted as being binding upon medical practitioners but rather be seen as a guide to appropriate changes, allowing each physician discretion in negotiating an individual fee with an individual patient.[1] To preserve both the profession's right to determine its fee schedule and the individual physician's discretion in particular cases, the Manitoba Medical Association has consistently encouraged its members to 'opt out' of the government insurance programme.

It is difficult to say precisely, the extent to which this official stance of the Manitoba Medical Association in the early post-medicare period reflected the mix of opinion within the profession as a whole. However, since the advent of medicare in 1969, the majority of the fee-for-service physicians chose contrary to Manitoba Medical Association advice, to submit at least some of their bills to the government plan. It is also difficult to ascertain how many physicians submitted bills direct to their patients. It is premature to describe the present situation as desperate. But a crisis is certainly an imminent possibility if the current inflationary increase in expenditure continues unchecked.

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[1] Interview with a non-medical official of the Manitoba Medical Association on 8/2/78.

The introduction of the Medical Care Act was not, however, merely the product of changing social demands; it was also an attempt to solve the major organizational problems implicit in the rapid expansion of medicine and medical specialization. The rising and potentially prohibitive cost of services to the patient was only one result of an increasingly effective diagnosis and treatment. Although the fee-for-service mechanism removed the financial barrier between doctor and individual patient, the overall question of cost remained in the form of concern over the amount of money the nation as a whole was willing and able to spend, and in the development of services of maximum efficiency. Except for efforts to redistribute doctors geographically in relation to population needs, and partial regionalization of medical services, medicare had provided no clear answer to the basic economic and organizational issues.

The present pattern of distribution of health care resources in Manitoba cannot be regarded as a co-ordinated and integrated system. There is widespread agreement that active treatment hospitals are over-emphasized relative, for example, to chronic and convalescent care facilities, nursing homes, home care programmes and preventive health services. The resulting and unnecessary high utilization of in-patient care, which also is most costly, represents a gross misallocation and waste of scarce capital and manpower resources.

When the Medical Care Act became law in 1969, there were other personal health services which were not included in this design. While it was apparent that the increase in specialized medicine would enhance the importance of the family doctor to give continuing care to the patient, existing General Practitioners were brought into the health service on conditions that continued their historical role as junior partners to hospital consultants. The pressures of specialization have intensified, and they will probably continue to do so.

Furthermore, a wide range of health personnel presently exists and additions could readily be generated which could substitute for expensive physicians and dentists. Current utilization of medical manpower involves considerable waste, in that many of the functions could be performed by less expensive personnel.[2] For example, the substitution of paramedical and nurses for medical personnel, substitution of orderlies for nursing staff, and the substitution of dental hygienists or dental assistants for dentists, has been accomplished in many jurisdictions.[3]

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[2] For example, see K. R. Smith et al., "An analysis of the optimal use of inputs in the production of medical services", Journal of Human Resources, 7 (Spring 1972): 208-255.

[3] Nurses or Nurse Practitioners might work in any one of four different situations: (1) as assistant to a physician or a group of physicians, (2) as associate of a physician and other health professionals, (3) in community health centres, such as those developing in some larger urban centres, (4) in nursing stations or similar facilities, established in isolated rural areas. See, Canada, Department of National Health and Welfare, Report of the Committee on Nurse Practitioners (Ottawa, April 1972); "Nurses to do more doctoring", Winnipeg Tribune, 12 April 1973. Sundry duties such as washing patients and cleaning teeth have been assigned to orderlies and dental assistants.

Medical manpower substitution may be an important aspect of the attempt to solve the uneven geographical distribution of physicians, dentists, and other personnel. Recent studies and reports on this and related issues confirm that there is, indeed, more potential for such substitution of manpower with resulting gains in productivity and reduction of expenditures.[4]

However, effective constraints to manpower substitution may not be of a technical-educational nature. Certain institutional factors may be more important barriers. For example, increased professionalization and unionization of health manpower in hospitals is said to result in a rigid occupational hierarchy which precludes the upward mobility of health personnel. This makes the reallocation of tasks across occupational boundaries increasingly difficult. The average physician in Manitoba still performs far too many tasks that could safely be delegated to nurses, or other types of medical assistants. The explanations for such behavior vary in emphasis. They include, among others, the fee-for-service method of paying the doctors, existing legal and licensing constraints, risks inherent in delegating tasks, consumer reaction and/or non acceptance.

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[4] Ontario, Office of the Minister of Health, The Nurse Practitioner in Primary Care. Report, 1975.

In the light of these constraints it is not enough to identify areas of viable and efficient substitution of manpower, even after the most careful and rigorous analysis of actual practices of physicians, dentists and nurses. The implementation of these functional changes must therefore be predicated on the elimination of the barriers to effective substitution.

In conclusion, any solution in the cost-benefit of the present system of medical care should focus attention on the main centres of power; the people, the government and the medical profession. The prime concern of the people is the availability of good medical care when needed; the immediate concern of the government is that medical care costs are disconcerting; while for many physicians the problem is that the time and effort required to satisfy patients' expectations for medical care precludes the physicians' reasonable expectations for enjoyment of life in contemporary society. These concerns will only be fulfilled if the principles of controlling costs through increased efficiency, and increasing efficiency through research, and validating research through compilation of sound data are accepted.

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